Evaluating the CARE Act

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

Christine Eibner and Sarah Nowak

May 2016

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ABSTRACT

The Patient Choice, Affordability, Responsibility, and Empowerment (CARE) Act is an alternative to the Affordable Care Act (ACA) offered by Sens. Richard Burr (R–N.C.) and Orrin Hatch (R–Utah) and Rep. Fred Upton (R–Mich.). It would eliminate the ACA's individual and employer mandates, loosen regulations on insurers, roll back funding for Medicaid expansion, eliminate taxes and fees, and offer tax credits to low-income individuals to help them purchase insurance. We analyzed the effects of the CARE Act on insurance enrollment, premiums, federal spending, and out-of-pocket costs, relative to current law. We estimate that, in 2018, the CARE Act would reduce federal spending but increase the deficit by $17 billion, relative to current law. It also would increase the number of uninsured individuals by 9 million, and leave some population segments, including low-income individuals and older adults, with substantially higher costs for health insurance and medical care.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new publications when they become available, visit the Fund's website and register to receive email alerts. Commonwealth Fund pub. 1878.

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Christine Eibner, Ph.D., is a senior economist at the RAND Corporation, and associate director for RAND's Health Services and Delivery Systems Research Program. Dr. Eibner's recent studies have considered changes in health insurance enrollment since 2013, use of pharmaceuticals among marketplace enrollees compared with employer-insured individuals, and geographic variation in marketplace premiums and cost-sharing. In addition, she has led a series of analyses using the RAND COMPARE microsimulation model to assess how changes to the ACA could affect key outcomes, including federal spending, Medicaid enrollment, and individual market coverage. Dr. Eibner's research has been published in journals such as *Health Affairs*, *Health Services Research*, and the *New England Journal of Medicine*. She earned her Ph.D. in economics from the University of Maryland and her bachelor's degree from the College of William and Mary.

Sarah Nowak, Ph.D., is a physical scientist at the RAND Corporation, specializing in mathematical modeling. Much of Dr. Nowak's recent work has focused on using the RAND COMPARE microsimulation model to evaluate health insurance reforms including assessing the impact of the ACA on individual and family spending, and how alternatives to current ACA provisions would impact health insurance coverage and enrollment, government spending, and families' health care spending. Dr. Nowak also led a recent study that used a survey of patients and agent-based modeling to examine the role of social networks on women's breast cancer screening decisions. Dr. Nowak holds a Ph.D. in biomathematics from the University of California, Los Angeles, and a bachelor's degree in physics from the Massachusetts Institute of Technology.

ACKNOWLEDGMENTS

We thank Chapin White and Paul Ginsburg for their thoughtful technical reviews of this document. David Adamson provided invaluable support in editing the document, helping us with wordsmithing, and responding to reviewer comments. We are also indebted to James Syme, who provided helpful research assistance, and Evan Saltzman, who provided feedback on key modeling decisions. We thank Stacy Fitzsimmons for providing excellent administrative assistance. Finally, we are grateful to Sara Collins and The Commonwealth Fund for their support of this project.

Editorial support was provided by Martha Hostetter.

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INTRODUCTION

Background

Since the Affordable Care Act (ACA) was enacted in 2010, the U.S. Department of Health and Human Services estimates that 20 million people have become newly insured, and approximately 24 million people have gained access to subsidized or free care through marketplace tax credits and Medicaid expansion.[1] Despite these successes, there have been repeated calls to repeal the law and replace it with an alternative set of policy reforms. Those wishing to replace the law often argue that it goes too far in imposing requirements on individuals, businesses, and health insurers. The individual mandate, requiring most Americans to obtain coverage or face penalties, and the employer mandate, requiring large businesses to offer coverage or face penalties, are particular targets of criticism. Those opposing the law also argue that regulations restricting insurers' ability to charge higher premiums to older and sicker adults may lead to unnecessarily high premiums for younger and healthier individuals. An additional concern is that the law could substantially increase federal spending in the long run, given the cost of Medicaid expansion and the ACA's approach to subsidizing health insurance coverage in the marketplaces. Both the Medicaid expansion and the marketplace tax credits offer a minimum level of benefits to individuals and restrict cost-sharing amounts in a manner that protects enrollees from rising health care spending. Many proponents of repeal-and-replace alternatives favor a premium-support approach, in which federal subsidies are based on a fixed amount that grows over time at a predictable rate (e.g., based on the Consumer Price Index, or CPI).

In this report, we analyze the effects of the Patient Choice, Affordability, Responsibility, and Empowerment (CARE) Act, a comprehensive proposal to repeal and replace the ACA offered by Senator Richard Burr (R–N.C.), Senator Orrin Hatch (R–Utah), and Representative Fred Upton (R–Mich.).[2] The CARE Act addresses many of the criticisms of the ACA raised by those wishing to repeal and replace the law, including capping federal Medicaid funding allotments, providing premium-support subsidies for low-income individuals, and relaxing health insurance rating regulations to allow age variation in premiums along the lines of variation in spending. The CARE Act would also eliminate the individual and employer mandates. To incentivize people to obtain health insurance, the CARE Act imposes a "continuous coverage" provision that would allow insurers to charge higher premiums or deny coverage to individuals who have not remained continuously enrolled.

One challenge in modeling options to repeal and replace the ACA is that there are many current proposals, and there is no clear coalescence around a single policy. We focus on the CARE Act because it is a relatively detailed proposal that addresses most of the standard criticisms of the ACA. Many other repeal-and-replace proposals contain similar ideas, although specifics vary. For example, like the CARE Act, proposals offered by Paul Ryan, Jeb Bush, John McCain, and Marco Rubio contained alternatives to the ACA's marketplace tax credits that involve premium-support tax credits. Among the various alternatives, the CARE Act offers a particularly useful subject for analysis because it was written by legislators who have contributed to the health care reform debate for decades, and builds on a related proposal offered in 2012 by Sens. Burr, Tom Coburn (R–Okla., now retired), and Hatch.

Overview of the CARE Act

Below, we describe the reforms introduced by the CARE Act:

Individual Market Reforms: The ACA requires insurers to offer coverage to all willing buyers at standard rates that vary only by age, place of residence, and smoking status. Older adults can be charged no more than three times as much as younger adults (3-to-1 rate banding). Under the CARE Act, insurers would be required to offer coverage to all willing buyers at standard rates that vary only by age and place of residence, as long as buyers maintain continuous coverage for at least 18 months. There would be a one-time open enrollment period during which standard rates would be offered to everyone, regardless of prior health insurance status. Insurers would be permitted to charge older individuals no more than five times as much as younger individuals (5-to-1 rate banding).

Tax Credits for Low-Income Individuals and Small-Business Workers: The ACA provides tax credits to individuals with incomes between 100 percent and 400 percent of the federal poverty level (FPL) who do not have access to employer-sponsored coverage (including small-group coverage) or Medicaid. These credits can be used to purchase coverage in the health insurance marketplaces. Eligible individuals must pay a percentage of their income toward health insurance premiums; in 2014 these percentages started at 2 percent for those with incomes between 100 percent and 138 of the FPL and rose to 9.5 percent for those with incomes between 300 percent and 400 percent of the FPL. Over time, the required contributions increase based on the ratio of premium growth to CPI growth, so that enrollees and the federal government share the costs of premium growth in excess of CPI growth. Once an individual or family reaches the required contribution amount, the federal government covers the remaining cost of coverage, up to the price of the second-lowest-cost silver plan available to the enrollee.[3] Those with incomes between 100 percent and 250 percent of the FPL are additionally eligible for cost-sharing reductions to defray the cost of copayments, deductibles, and other cost-sharing.

The CARE Act would offer refundable, advanceable (i.e., credits are available upfront, rather than delayed until the end of the tax year), means-tested tax credits to small-business workers and individuals who 1) do not work for a large business, and 2) do not have an alternative offer of health insurance. The tax credit amounts would vary with age, income, and family status. Those with incomes below 200 percent of the FPL would be eligible for the full amount of the tax credit, and the value of the credit would fall to zero as income approaches 300 percent of the FPL. Small-business workers could apply their credits to a small-group plan (if offered) or to individual-market coverage. Medicaid-eligible individuals could opt to use the credit rather than enrolling in the Medicaid program. Because the credit would increase over time based on CPI plus one percentage point, enrollees would bear the full cost of any premium growth that exceeded that. We consider the CARE Act tax credits to reflect a "premium-support" model of health insurance subsidization because they are not adjusted based on regional variation in premium levels or health care cost growth.

Exhibit 1 shows the tax credit schedule proposed in the CARE Act for individuals and families with income under 200 percent of the FPL.

Exhibit 1

CARE Act Tax Credits, 2014

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

Notes: Tax credits are proposed for 2014, and would increase with CPI+1 in subsequent years. Those with incomes <200 percent of the federal poverty level (FPL) are eligible for the full tax credit. The value of the credit declines for individuals with incomes between 200 percent and 300 percent FPL, and is zero for those with higher incomes.

CARE Act Tax Credits vs. ACA Tax Credits

The premium tax credits offered by the CARE Act differ substantially from the ACA tax credits in terms of amounts, eligibility criteria, and the degree to which they scale with income and age. As a result, some people will pay more for health insurance under the CARE Act relative to the ACA, and some will pay less. Exhibit 2 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. In some cases, 40-year-olds fare better than 30-year-olds 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 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 fare better than those at the top.

Exhibit 2

Percent of Families Eligible for Premium Subsidies Under the ACA Who Would Pay Less for a 70 Percent Actuarial Value Plan Under the ACA Relative to the CARE Act

Age of adults in family	Single	Couple (both spouses same age)	Family of four (both parents same age)
21	15%	0%	66%
30	41%	75%	95%
40	25%	25%	80%
50	100%	80%	100%
60	100%	100%	100%

Notes: ACA tax credit amounts are estimated based on output from the RAND COMPARE microsimulation model. Orange shading indicates that the majority of families fare better under the CARE Act; blue shading indicates that the majority of families fare better under the ACA.

Medicaid Capped Allotment: The ACA allows states to expand Medicaid to cover all individuals with incomes at or below 138 percent of the FPL. The CARE Act would eliminate funding for this expansion. Instead, federal funding for Medicaid would reflect a capped allotment based on pre-2014 spending in each state, adjusted for inflation (based on growth in the CPI plus 1 percentage point) and demographic change.

We assume that, with the elimination of federal funding for Medicaid expansion, all states would roll back their Medicaid eligibility thresholds to pre-ACA levels. Because the capped allotment allows states flexibility in managing their Medicaid programs, it is possible that some states would maintain expansion and finance the extra costs with state funds. We assume this possibility is unlikely because—under current law—the federal government finances at least 90 percent of Medicaid expansion costs, and states would be hard-pressed to make up this difference. Further, while the CARE Act would not continue to support Medicaid expansion, it would allow many individuals with incomes in the Medicaid-expansion range (<=138 percent of the FPL) to obtain means-tested tax credits to purchase private insurance.[4]

State High-Risk Pools: Under the CARE Act, states would have the option to implement high-risk insurance pools for people with costly conditions, using targeted federal funding. High-risk pools would keep the most expensive people out of the individual health insurance market, reducing premiums for the remaining population.

Malpractice Reform: Although medical malpractice reform has been a perennial area of focus among many of those seeking to reduce health spending in the U.S., the ACA did not make direct changes to medical malpractice law. The CARE Act, in contrast, supports a "range of solutions to tackle the problem of junk lawsuits and defensive medicine." Although the proposal lacks specificity on what malpractice reforms would be adopted, it offers at least four examples of potential reforms, including capping noneconomic damages (e.g., compensation for pain and suffering), limiting attorneys' fees, encouraging the adoption of dispute resolution through expert panels, and adopting payment compensation reforms modeled after workers' compensation.

Tax Exclusion Cap for Employer-Sponsored Insurance: The ACA imposed a 40 percent excise tax on employer health insurance plans with premiums above $10,200 for individuals and $27,500 for families. However, this change was delayed, and is not expected to take effect until 2020. The CARE Act would make a slightly different change to the tax treatment of employer insurance, capping the existing tax exclusion at $12,000 for single coverage and $30,000 for family coverage. These caps would be indexed to grow at CPI plus one percentage point.

There are several additional provisions of the CARE Act that we do not model in this report, including targeted changes to eligibility for Health Savings Accounts and reforms aimed at increasing transparency in the health care system. In general, we have not modeled these provisions because implementation details in the CARE Act proposal are sparse. In addition, some of these provisions are dependent on state decisions, which are difficult to predict. We provide a more complete description of the reforms proposed in the CARE Act in the Appendix to this report.

Medicare Reform Under the CARE Act

One important aspect of the ACA that the CARE Act *does not* change involves Medicare reform. The ACA implemented many changes to the Medicare program, including reducing the growth of payment rates over time, penalizing hospitals with excessive readmission rates, and imposing an additional hospital insurance tax on individuals with high incomes. The Congressional Budget Office estimates that these changes will reduce the deficit by $802 billion between 2016 and 2025, with $44 billion in savings in 2018.[5] Based on the text of the CARE Act, we assume these Medicare reforms will remain in place. We further assume that the CARE Act will retain the ACA's increase in the Medicare hospital insurance tax, which is levied on those with incomes over $200,000 for single individuals or $250,000 for married couples.

RESEARCH FINDINGS

Methods

We assessed the effects of the CARE Act using the RAND COMPARE microsimulation model, an analytic tool that uses economic theory and data to estimate the effects of health policy changes. COMPARE creates a representation of the U.S. population using data from the Survey of Income and Program Participation (SIPP), the Medical Expenditure Panel Survey (MEPS), and the Kaiser Family Foundation/Health Research and Educational Trust (KFF/HRET) Annual Survey of Employer Benefits. In the model, simulated people and businesses make decisions about whether to enroll in health insurance or, if a business, offer coverage by weighing the costs and benefits of available options, taking into account tax credits and other inducements. The model accounts for regulatory policies and incentives, including rate-banding policies, insurers' ability to deny coverage or levy upcharges for those with preexisting conditions, individuals' financial risk associated with remaining uninsured, and the availability of tax credits to purchase insurance. The Appendix provides a more detailed overview of COMPARE, as well as information on the specific approaches we have taken to model the CARE Act.

Coverage

Exhibit 3 shows the estimated effects on insurance enrollment, overall and by source of coverage. We include columns for the ACA and the CARE Act, as well as a "no reform" scenario. The "no reform" column reflects outcomes that could be expected if the ACA had never been enacted. All results are estimated for the year 2018.

Exhibit 3

Total Insured Under Alternative Health Reforms, Overall and by Source of Coverage (millions of individuals under age 65), 2018

	No Reform	ACA	CARE Act
Total insured	224.7	251.5	242.5
Employer insurance	155.6	158.3	157.4
Large employer	115.6	122.4	117.9
Small employer	40.0	35.9	39.5
Individual market coverage*	11.4	23.9	33.3
Regular-risk pool	11.4	23.9	33.0
High-risk pool	0.0	0.0	0.3
Total Medicaid	45.9	57.2	39.6
Other	11.8	12.2	12.2
Uninsured	49.7	27.7	36.7

* Individual market coverage in the ACA scenario includes both marketplace and off-marketplace plans.
Notes: Results are based on output from the RAND COMPARE microsimulation model, with outcomes estimated for the year 2018. The population analyzed includes all U.S. residents under age 65. The "other" insurance category includes Medicare and military coverage.

Relative to the no-reform scenario, both the ACA and the CARE Act increase the size of the insured population. However, the ACA insures about 9.0 million more people than the CARE Act. We estimate that about 17.6 million people would disenroll from Medicaid under the CARE Act relative to the ACA, either because they are no longer eligible or they opt to use the CARE Act's tax credit rather than retaining Medicaid coverage. Simultaneously, individual-market coverage would increase by a net 9.4 million relative to the ACA, not enough to fully offset the declines in Medicaid enrollment. The net increase in individual-market enrollment reflects a gross influx of 20.9 million people into the individual market, mostly from Medicaid (12.4 million new enrollees) and from the ranks of the uninsured (5.9 million new enrollees), which is partially offset by a gross 11.5 million person decline in individual-market enrollment. The large influx from Medicaid stems from the fact that the CARE Act eliminates funding for Medicaid expansion but enables people in the Medicaid-eligible range to receive means-tested tax credits to enroll in individual-market plans. Those moving into the individual market after being uninsured tend to be young, and would thus face lower premiums with the CARE Act, as well as those who receive higher tax credits under the CARE Act relative to the ACA (see Exhibit 2 and Appendix Table A.4). Those who leave the individual market tend to be older, and would thus face higher premiums under the CARE Act, as well as those who receive lower tax credits under the CARE Act than under the ACA. Nearly 80 percent of the 11.5 million people who transition out of the individual market under the CARE Act would become uninsured.

There also would be about 900,000 fewer employer-sponsored insurance enrollees under the CARE Act than under the ACA. This decline occurs because some firms and workers would drop employer coverage under the CARE Act because of the elimination of the employer and individual mandates. The overall decline, however, masks very different trends for small and large businesses. Small-group coverage would increase under the CARE Act relative to the ACA, because of new tax credits available to small-group enrollees. However, large-employer coverage would fall under the CARE Act relative to the ACA. As modeled, some married couples and families with access to both small- and large-employer health insurance would drop large-employer coverage and enroll in the small-group market to take advantage of the CARE Act's small-group tax credits. In reality, it is unclear from the CARE Act whether families with both large- and small-business workers would be eligible for tax credits. The CARE Act emphasizes that a key purpose of the tax credits is to provide assistance to small businesses and their workers, but precludes large-business workers from receiving the credits. The proposal does not address how married couples would be handled in cases where one spouse works for a large employer and the other spouse works for a small employer. In sensitivity analyses, reported in the Appendix, we consider a more restrictive reading of the proposal that precludes family members from accessing tax credits if one spouse works for a large business.

We estimate that relatively few people (300,000) would enroll in the high-risk pool. In part this is driven by assumptions; we assume that only people with extremely high risk of health spending would be eligible. Details on exactly how the high-risk pool would be implemented, and who would be eligible, are sparse. In sensitivity analyses (reported in the Appendix), we explore alternative approaches to modeling the high-risk pool.

Age and Income Distribution of the Uninsured

In addition to their differing effects on the overall number of people insured and the distribution of coverage across public and private sources, the ACA and the CARE Act may have different implications for the number of uninsured in different demographic groups. Because the CARE Act allows insurers to charge higher premiums to older people to reduce the costs for younger enrollees, it might affect the age distribution of the uninsured. Similarly, the CARE Act might have implications for the income distribution of uninsured individuals. While the CARE Act would repeal the Medicaid expansion, it extends tax credits to low-income people in all states. In contrast, the 2012

Supreme Court decision allowing states to opt out of the ACA's Medicaid expansion left low-income individuals without coverage in many states.

In Exhibit 4, we explore these issues by comparing the uninsured populations under the ACA and the CARE Act by age and family poverty category. The results suggest that uninsurance would increase across all age and income categories under the CARE Act relative to the ACA. These increases, however, would be most pronounced for individuals ages 50 to 64, among whom the number of uninsured approximately doubles across the two scenarios. The CARE Act also would lead to a notable increase in the number of uninsured children because its family premium tax credits do not increase with family size. It also would increase the number of uninsured among those with incomes above 400 percent of the FPL. A disproportionate share of older individuals, who now face higher individual-market premiums, fall into this higher-income range. The repeal of the individual mandate also causes some individuals to drop coverage.

Exhibit 4

Uninsured by Age and Family Poverty Category, ACA vs. CARE Act (millions of individuals)

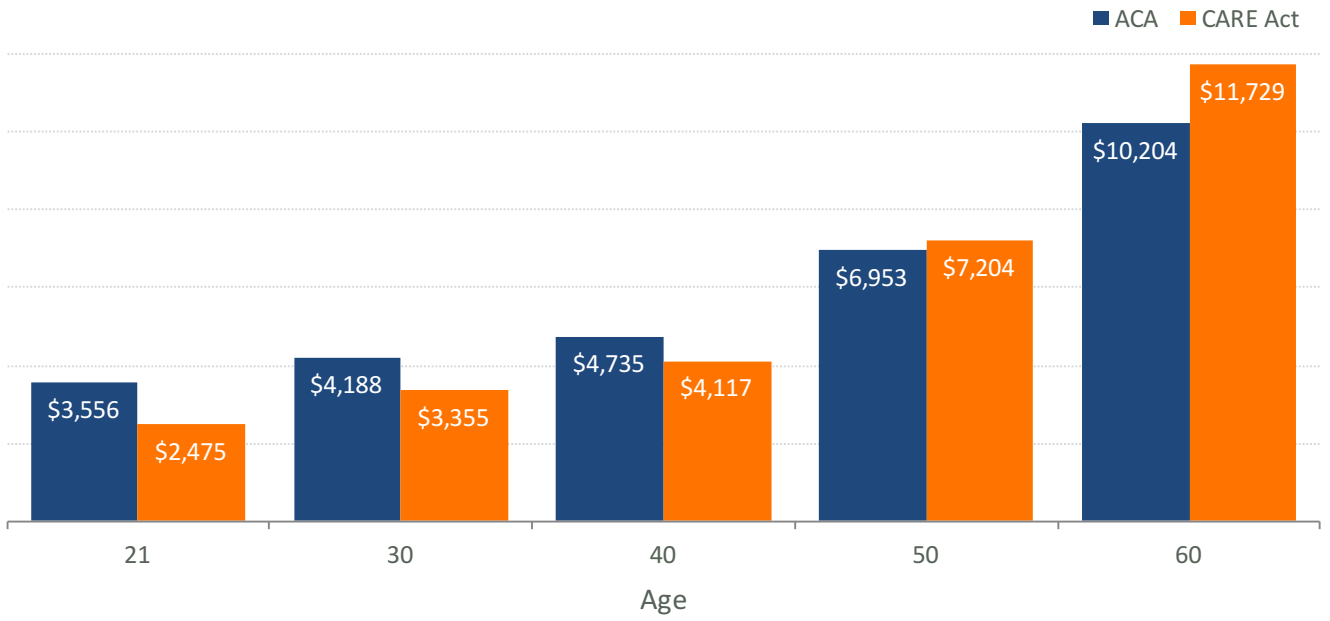
	ACA	CARE Act	Difference (CARE Act - ACA)
Uninsured by age			
<18	**3.8**	6.3	2.5
18–34	**12.8**	13.6	0.9
35–49	**6.5**	7.8	1.2
50–64	**4.5**	9.0	4.5
Uninsured by family poverty category			
<=138% FPL	17.1	18.2	1.1
138% FPL to 200% FPL	2.2	4.1	1.9
201% FPL to 300% FPL	2.9	5.0	2.0
301% FPL to 400% FPL	2.1	3.8	1.7
401% FPL and up	3.3	5.6	2.3

Notes: FPL = federal poverty level. Estimates based on output from the RAND COMPARE microsimulation model.

One reason why older adults would have higher uninsurance rates under the CARE Act relative to the ACA is that the CARE Act allows insurers to charge older people higher premiums. Exhibit 5 shows estimated 2018 individual-market premiums for a 70 percent actuarial value plan (e.g., a silver plan on the marketplaces), by age, under the two reforms. As expected, premiums for adults under age 50 would be lower under the CARE Act compared with the ACA, while premiums for adults age 50 and older would be higher.

Exhibit 5

Individual Market Premiums (for a 70% actuarial value plan) by Age, ACA vs. CARE Act, 2018



Notes: Premiums estimates based on output from the RAND COMPARE microsimulation model. Estimates for the ACA reflect total premiums (before tax credits) for nonsmokers.

Federal Deficit Impact

While the CARE Act would reduce federal Medicaid spending obligations, it would provide new tax credits for individual and small-group coverage. Both of these changes could affect federal outlays. Simultaneously, the CARE Act would eliminate several sources of revenue, including the individual and employer mandates, and various taxes and fees imposed by the ACA. Other differences between the two proposals that could affect the federal deficit include the federally funded high-risk pools authorized under the CARE Act, new medical malpractice regulations under the CARE Act, and differences between the two reforms in the tax treatment of high-cost employer health plans. Exhibit 6 shows the estimated effects of each policy on the federal deficit.

Federal spending under the CARE Act would fall by $27 billion in 2018 relative to the ACA. This reduction would be driven primarily by the $62 billion decrease in federal Medicaid spending. While the CARE Act would increase spending on individual and small-group tax credits relative to the ACA, the net effect of the CARE Act on spending would be negative. Despite the net decrease in subsidies for health insurance, we estimate that the CARE Act would increase the federal deficit by $17 billion in 2018 relative to the ACA. This increase would be driven primarily by a loss of federal revenue. The ACA generates $48 billion in federal revenue as a result of the individual mandate, the employer mandate, the section 9010 tax on group health insurers, a tax on tanning services, fees on branded prescription drugs and medical devices, and several other tax reforms. The CARE Act would repeal these revenue-generating measures and add only $3 billion in new tax revenue, stemming from a tax on high-cost health plans and medical malpractice reform. The $2 billion increase in revenue from malpractice reform would come from additional income and payroll taxes that could be collected if employer health insurance premiums fell because of reduced malpractice costs and wages, in turn, increased.

Exhibit 6

Federal Deficit Impact (in $ billions) Relative to "No Reform" Scenario, ACA vs. CARE Act, 2018

	ACA	CARE Act	Difference (CARE Act - ACA)
Additional federal outlays			
Medicaid and CHIP spending	$54	-$8	-$62
Premium tax credits	$61	$79	$18
Cost-sharing subsidies	$4	$0	-$4
Small-group tax credits	$0	$26	$26
High-risk pool	$0	$2	$2
Malpractice reform	$0	-$6	-$6
Total outlays	$119	$92	-$27
Additional federal revenues			
Individual mandate	$8	$0	-$8
Employer mandate	$13	$0	-$13
Tax on high-cost health plans	$0	$1	$1
Revenue from malpractice reform	$0	$2	$2
Revenue from ACA taxes and fees*	$27	$0	-$27
Total revenue	$48	$3	-$45
Net deficit impact (outlays – revenue)	$72	$89	$17

* Excludes revenues from the ACA's increased Medicare hospital insurance tax, which we assume will be retained under CARE Act.
Notes: Estimates based on output from the RAND COMPARE microsimulation model. Numbers may not sum to exact values because of rounding.

Individual and Family Spending

Exhibit 7 considers the effects on health care spending among insured individuals and families under both the CARE Act and the ACA. We do not include uninsured people in these estimates because those without insurance typically spend less money on health care, but face a higher risk of catastrophic financial loss because of an unexpected health need and are more likely than insured individuals to forgo necessary care. Total health spending in this framework includes premium contributions net of any tax credits received or employer contributions and out-of-pocket spending net of any cost-sharing subsidies. In addition to average spending, we also consider the share of families spending more than 10 percent and more than 20 percent of their income on health care.

Among all insured individuals, we find that premium spending would fall slightly while out-of-pocket spending would increase slightly under the CARE Act relative to the ACA. In addition, a slightly higher share of individuals and families would face health spending in excess of 10 percent or 20 percent of income under the CARE Act relative to the ACA. However, these differences are small and may mask important differences in spending for different population subgroups.

Exhibit 7

Differences in Average Health Spending, Families and Individuals Enrolled in Insurance, ACA vs. CARE Act, 2018

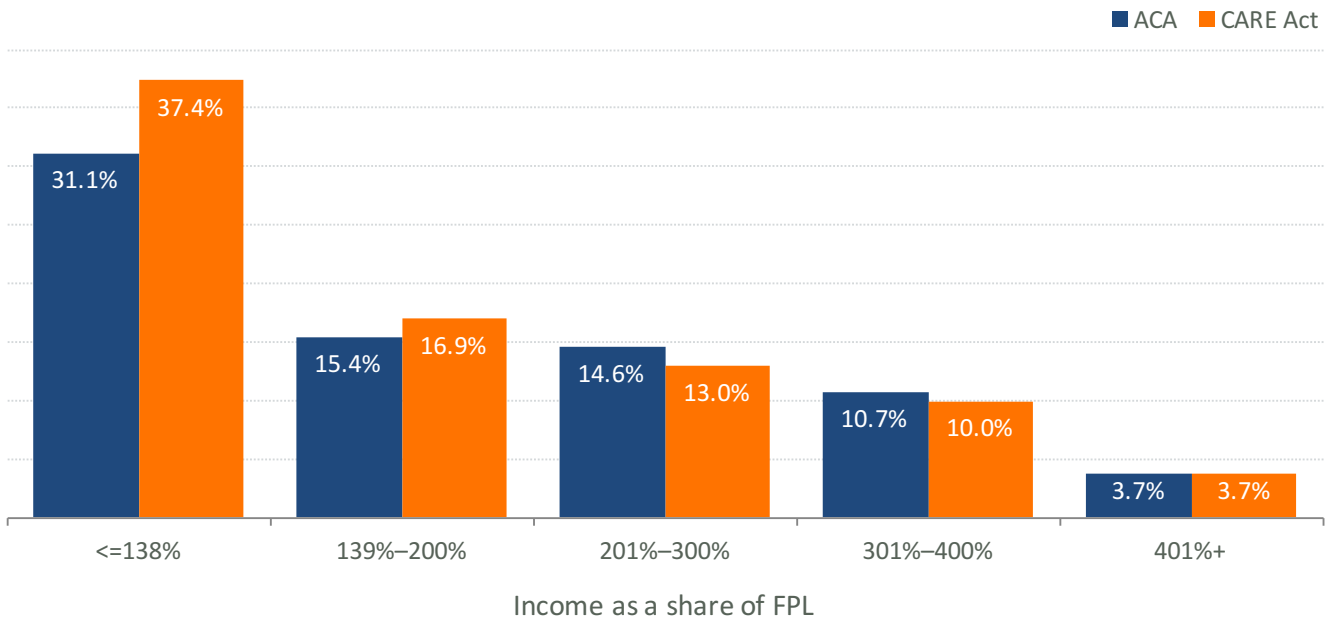
	ACA	CARE Act
Premium contributions (A)	$1,292	$1,269
Out-of-pocket spending (B)	$655	$682
Total health spending (A+B)	$1,947	$1,951
Share spending more than 10% of income on health care	14.7%	16.1%
Share spending more than 20% of income on health care	7.6%	8.8%

Notes: Estimates based on output from the RAND COMPARE microsimulation model. Premium contributions include premium spending net of employer contributions and tax credits. Out-of-pocket spending includes spending on copayments, deductibles, and other cost-sharing. The universe for the analysis includes people who are insured under both the ACA and the CARE Act. Individuals who are uninsured in either scenario are excluded (including those who are insured under one plan, but not the other).

Because one of the major differences between the ACA and the CARE Act is that the latter eliminates funding for Medicaid expansion and replaces it with tax credits for low-income individuals, spending differences by income might be of particular interest. Exhibit 8 shows the spending effects for people in different income ranges,

Exhibit 8

Percent of Families Spending More Than 10 Percent of Income on Health Care by Family Poverty Category, All Individuals and Families Enrolled in Insurance, ACA vs. CARE Act, 2018



Notes: FPL = federal poverty level. Estimates based on output from the RAND COMPARE microsimulation model. Health care spending includes the sum of premium contributions (net of employer contributions and tax credits) and out-of-pocket spending (e.g., copayments, deductibles).

focusing on the share who spend more than 10 percent of their income on health care, a commonly used measure of health care cost burden.[6] For low-income individuals and families, particularly those with incomes at or below 138 percent of the FPL, the share spending more than 10 percent of income on health would be higher under the CARE Act than under the ACA.

Exhibit 9 explores this issue in more detail, focusing specifically on the 12.4 million people who would transition from Medicaid to individual-market coverage under the CARE Act.

For low-income people who transition from Medicaid to individual-market coverage, average total health spending would rise from $96 per year under the ACA to $1,429 per year under the CARE Act. In addition, we estimate that this group would face large increases in health spending relative to income; the share of individuals paying more than 10 percent of their income toward health care would rise from 41 percent to 70 percent.

Exhibit 9

Differences in Average Health Spending, Families and Individuals Who Transition from Medicaid to Individual-Market Coverage, ACA vs. CARE Act, 2018

	ACA	CARE Act
Premium contributions (A)	$0	$972
Out-of-pocket spending (B)	$96	$457
Total health spending (A+B)	$96	$1,429
Share spending more than 10% of income on health care	40.9%	70.4%
Share spending more than 20% of income on health care	39.6%	57.0%

Notes: Estimates based on output from the RAND COMPARE microsimulation model. Premium contributions include premium spending net of employer contributions and tax credits. Out-of-pocket spending includes spending on copayments, deductibles, and other cost-sharing.

Another group at particular risk for high spending under the CARE Act includes adults ages 50 to 64 who enroll in individual-market coverage. As shown in Exhibit 5, these individuals may face higher premiums under the proposal because of 5-to-1 rate banding. In Exhibit 10, we report health spending outcomes for individual-market enrollees ages 50 to 64; the analysis includes spending for single adults in this age range, as well as for families in which at least one member is between the ages of 50 and 64.

Exhibit 10 indicates that individuals and families with household members between the ages of 50 and 64 would face substantially higher costs under the CARE Act if they enroll in individual-market coverage. We estimate that total health spending by those in this group would increase from $5,654 to $9,544, a difference of 69 percent. In addition, the probability of spending more than 10 percent of income on health care would increase by nearly 36 percentage points, and the probability of spending more than 20 percent of income on health care approximately would triple.

Exhibit 10

Differences in Average Individual-Market Health Spending, Individuals and Families with Oldest Member Between the Ages of 50 and 64, ACA vs. CARE Act, 2018

	ACA	CARE Act
Premium contributions (A)	$4,280	$7,631
Out-of-pocket spending (B)	$1,375	$1,913
Total health spending (A+B)	$5,654	$9,544
Share spending more than 10% of income on health care	49.9%	85.4%
Share spending more than 20% of income on health care	18.1%	59.5%

Notes: Estimates based on output from the RAND COMPARE microsimulation model. Premium contributions include premium spending net of employer contributions and tax credits. Out-of-pocket spending includes spending on copayments, deductibles, and other cost-sharing. Analysis focuses on individual market enrollees only, and excludes people who would enroll in the individual market under the ACA but would be uninsured under the CARE Act.

LIMITATIONS

Like all models, RAND COMPARE has limitations. We assume that people behave rationally, making health insurance choices by weighing the costs and benefits of available options. In reality, consumer confusion over insurance products may reduce the chance that an individual makes a rational choice. Estimating the effects of penalties and incentives to encourage health insurance enrollment is particularly challenging. We have only two years of experience to date with the individual mandate, and—because people don't pay penalties until tax season during the following year—there are limited data available to estimate how well the individual mandate is enforced or who has complied.

We have a similar challenge in estimating how people will respond to the CARE Act's continuous coverage provisions. While the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides some protections that parallel the continuous coverage provisions proposed under the CARE Act, there are key differences, including the CARE Act's one-time open enrollment period. Our approach to estimating the effects of the CARE Act assumes that people will look ahead for one year and consider the potential future costs of facing higher charges or being denied coverage when making insurance decisions. In the Appendix, we report sensitivity analyses in which people ignore future costs when making current year insurance decisions and in which people look ahead for two years when making decisions.

Because there is no legislative language or set of regulations describing specific aspects of the proposal in detail, we had to make assumptions about how the CARE Act would be implemented. In some cases, these implementation decisions could have important effects on results. For example, it is unclear in the current proposal how tax credit eligibility would be determined for married couples in which spouses work for firms of different sizes. There is also uncertainty in the proposal regarding which states will implement optional reforms such as high-risk pools, and what type of minimum generosity requirements might be imposed on health plans to meet requirements for the continuous coverage provisions and tax credit eligibility. We assume that individuals must obtain a plan with an actuarial value of at least 60 percent in order to use the tax credit or to fulfill the continuous coverage provisions.

If no minimum benefit limits are established, it is possible that insurance companies could develop extremely limited plans that cost no more than the tax credit amounts. If this were to occur, the number of people covered under the CARE Act and the number of enrollees facing substantial out-of-pocket spending could be higher than estimated in this report.

With more detail on these specific issues, we would be able to develop a more precise estimate of the costs and benefits of the CARE Act proposal, and it is possible our results would be different from those estimated here. In sensitivity analyses presented in the Appendix, we address some of these uncertainties. None of these analyses revealed a case in which the CARE Act insured more people with a smaller deficit impact than the ACA.

POLICY IMPLICATIONS

Relative to the ACA, we estimate that the CARE Act would insure fewer people, raise the federal deficit, and impose greater financial burden on some vulnerable groups, including older adults and people with incomes under 138 percent of the FPL. We caution, however, that the increase in the deficit associated with the CARE Act is the result of the repeal of numerous small revenue-generating taxes and fees enacted under the ACA. If the CARE Act were turned into a bill, it is possible that legislators would seek to retain some of the ACA's revenue-generating provisions, or to adopt alternative revenue-generating provisions. If we ignore the revenue effects and focus only on spending, the CARE Act leads to a reduction in federal outlays relative to the ACA.

In addition to addressing the likely revenue shortfalls, policymakers who are considering adopting the CARE Act or related reforms might want to pay particular attention to older adults and low-income individuals and consider how to prevent them from experiencing financial strain and adverse health outcomes. Options could include adding cost-sharing subsidies in addition to tax credits, increasing subsidy amounts for older adults, or ensuring that funding remains available for states opting to retain Medicaid expansion. Notably, the CARE Act is one of relatively few repeal-and-replace proposals in which tax credits are means-tested. For example, a proposal offered by Rep. Tom Price (R–Ga.) in 2015 included tax credits that scaled with age but not income. Proposals that offer the same tax advantage to everyone, without consideration of financial need, may increase the financial strain on lower-income families.

Policymakers wishing to retain the ACA might consider whether there are any policy options included in the CARE Act that would be worthwhile to pursue in addition to current law. For example, the ACA did little to address medical malpractice costs, yet the Congressional Budget Office (CBO) estimates that adopting medical malpractice reform options could save around $8.4 billion in 2018 and $54 billion over a 10-year time horizon.[7] While the reforms modeled by the CBO do not fully parallel the reforms suggested in the CARE Act, the text of the CARE Act implies that a range of malpractice reforms would be considered.

Another consideration is the effect of the two policies on labor market and employment incentives. The ACA imposes a steep marginal tax rate on people as they transition from Medicaid eligibility (income less than or equal to 138 percent of the FPL in expansion states) to marketplace tax credit eligibility (between 139 percent and 400 percent of the FPL). Steep marginal tax rates could reduce the incentive for people with incomes just below 138 percent of the FPL to earn additional income.[8] The CARE Act addresses this distortion by offering the same tax credits to individuals with incomes below and immediately above 138 percent of the FPL, and by eliminating funding for Medicaid expansion. The consequence of this approach, however, is that low-income individuals are less protected against high health care spending relative to the ACA.

At the same time, the CARE Act may create other distortions by offering new tax credits for small-business employees to obtain health insurance. These tax credits are added on top of existing tax advantages for

employer-sponsored coverage, the cost of which is currently excluded from income and payroll tax calculations. Our analysis predicts that the strong tax advantages offered to small businesses under the CARE Act will cause 3.6 million people to gain coverage through a small employer, including people who switch from large-employer to small-employer coverage if, for example, they have small-group eligibility through a spouse. An additional effect, which we do not model, is that some large firms may opt to split into small firms and some small firms may limit size growth in order to gain or maintain eligibility for these substantial tax advantages. Prior work has shown that health insurance rating reforms targeted at firms of specific sizes may influence hiring and growth decisions.[9]

CONCLUSION

There are currently many proposals to repeal and replace the Affordable Care Act, including proposals offered by presidential candidate Donald Trump, Rep. Tom Price (R–Ga.), and former presidential candidates including Jeb Bush, Scott Walker, and Marco Rubio. Interest in such proposals may increase as the 2016 presidential election approaches. Our analysis of the CARE Act, a longstanding and relatively detailed repeal-and-replace proposal, suggests that finding an approach that insures the same number of people while simultaneously reducing federal costs will be difficult. We estimate that the CARE Act will increase the federal deficit relative to the ACA, while insuring fewer people. Further, the CARE Act leads to higher individual spending among some subsets of enrollees. In particular, older adults who enroll on the individual market pay higher premiums than they would under the ACA, and low-income individuals who would have otherwise enrolled in Medicaid face both higher premiums and higher cost-sharing. A disproportionate share of older adults also becomes uninsured under the CARE Act relative to the ACA. Because older adults tend to have more significant health care needs, an increase in the size of the uninsured population ages 50 to 64 could lead some individuals to have adverse health outcomes.

As described above, there are many uncertainties regarding CARE Act implementation decisions that could affect our estimates. However, based on sensitivity analyses reported in the Appendix, we believe that—even under alternative assumptions—the combination of policies offered by the CARE Act is unlikely to insure more people at a lower cost to the federal government than the ACA.

While the CARE Act would likely insure fewer people than the ACA, it would eliminate federal mandates and relax regulations that affect businesses in general and insurance companies in particular. For many critics of the ACA, there is a genuine tension between the goals of reducing the number of federal requirements imposed on businesses and individuals and keeping people insured. Whether reducing federal involvement and oversight of health care markets is worth having potentially greater numbers of uninsured requires a value judgement. Different citizens and policymakers are likely to have different opinions about whether such a trade-off would be worthwhile.

Our analysis also demonstrates that, as currently specified, the CARE Act is unlikely to reduce the federal deficit. Policymakers seeking to adopt the CARE Act, or to pursue a similar repeal-and-replace policy, may need to maintain some of the ACA's revenue-generating provisions, adopt alternative revenue-generating provisions, or reduce the generosity of tax credits to achieve budget neutrality.

Notes

[1] Centers for Medicare and Medicaid Services, *Medicaid & CHIP: November 2015 Monthly Applications, Eligibility Determinations and Enrollment Report* (CMS, Jan. 27, 2016); N. Uberoi, K. Finegold, and E. Gee, *Health Insurance Coverage and the Affordable Care Act, 2010–2016,* ASPE issue brief (Office of the Assistant Secretary for Planning and Evaluation, March 3, 2016); and Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report,* ASPE issue brief (ASPE, March 10, 2015).

[2] U.S. Senate Committee on Finance, "Burr, Hatch, Upton Unveil Obamacare Replacement Plan," news release (Senate Finance Committee, Feb. 5, 2015).

[3] The silver plan, on average, covers 70 percent of an enrollee's health care expenses.

[4] Individuals working for large employers would be ineligible for tax credits, regardless of income.

[5] Congressional Budget Office, *Budgetary and Economic Effects of Repealing the Affordable Care Act,* pub. no. 50252 (CBO, June 2015).

[6] J. Abramowitz and B. O'Hara, "The Financial Burden of Medical Spending: Estimates and Implications for Evaluating the Impact of ACA Reforms," *Medical Care Research and Review,* April 2015 72(2):187–99; and P. J. Cunningham, "The Share of People with High Medical Costs Increased Prior to Implementation of the Affordable Care Act," *Health Affairs,* Jan. 2015 34(1):117–24.

[7] D. W. Elmendorf, "Letter dated October 9, 2009, from Douglas W. Elmendorf, Director, Congressional Budget Office, to the Hon. Orrin G. Hatch, U.S. Senate," (CBO, Oct. 9, 2009).

[8] C. B. Mulligan, *Average Marginal Labor Income Tax Rates Under the Affordable Care Act,* NBER working paper no. 19365 (National Bureau of Economic Research, Aug. 2013).

[9] K. Kapur, P. Karaca-Mandic, S. M. Gates et al., "Do Small-Group Health Insurance Regulations Influence Small Business Size?" *Journal of Risk and Insurance,* March 2012 79(1):231–60.

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