The American Health Care Act Would Deliver Coverage in Name Only for Many With Unaffordable Deductibles

Introduction

The American Health Care Act (AHCA), passed by the U.S. House of Representatives in May, would make a number of important changes to the current system of covered benefits and financial subsidies under the Affordable Care Act (ACA). Among those changes, the AHCA would repeal means-tested Advanced Premium Tax Credits (APTC) under the ACA. The APTC adjusts based on age, income level and the price of the second-lowest cost Silver plan in a region to help individuals purchase affordable plans. Under the AHCA, enrollees with an annual income of up to $75,000 would receive a flat-dollar tax credit that adjusts only according to age, with tax credits phasing out at higher income levels. The AHCA would also allow states to waive the ten Essential Health Benefits (EHB) requirement, permitting health plans to exclude coverage for drugs, maternity care, mental health or other service categories.

Much of the commentary and analysis of the AHCA, including analysis conducted by the Congressional Budget Office[1] and the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary (OACT)[2], includes projections of the number of Americans that would be "covered" subsequent to enactment of the AHCA. A central question that needs to be answered is: ***covered for what?***

This Issue Brief seeks to shed light on this question, and the answers are troubling. It appears for many consumers, coverage

Summary of Findings:

- A recent report from the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary found that using current ACA benefit designs, a "Silver Tier" plan would move from having an annual deductible of $3,000 to an annual deductible of over $7,250 under the AHCA.
- The idea of providing tax credits to fund "no-cost" health plans that are fully covered (i.e. no monthly premium by enrollees) provides an important window on the potential affordability of care and demonstrates that many enrollees would have very skimpy health coverage similar to, or even less than, the individual market before the Affordable Care Act (ACA).
- Plan offerings that have no monthly premium would mean consumers aged 27 to 60 years old would have to pay out-of-pocket costs for the first $10,000 to $39,000 for the cost of care in a median-cost county to meet deductibles.
- If the AHCA's current age-based subsidy levels do not adjust according to regional cost variation, enrollees in high-cost regions will have a much higher deductible than enrollees in low-cost regions. For the 20 percent of Americans living in higher-cost regions, deductibles would be still higher, from $17,000 to $58,000 depending on age.
- Deductibles in plans that have no monthly premiums would be so high as to render the coverage to be of little or no value to low-income and older consumers.

This analysis was prepared by Covered California for its ongoing planning and to inform policy making in California and nationally.

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would be in name only and they would need to spend far more out-of-pocket than they could afford or, for many, even than what was available before the Affordable Care Act.

Overview of Changes in Cost Sharing

The Congressional Budget Office (CBO) analysis of the AHCA concluded that based on the changes in Medicaid funding and subsidies, by 2026, about 24 million Americans would lose coverage compared to under the ACA. The CBO report notes "insurance policies would provide fewer benefits" and that plans would "cover a smaller percentage of health care costs," but it did not expressly detail how much coverage would be reduced.

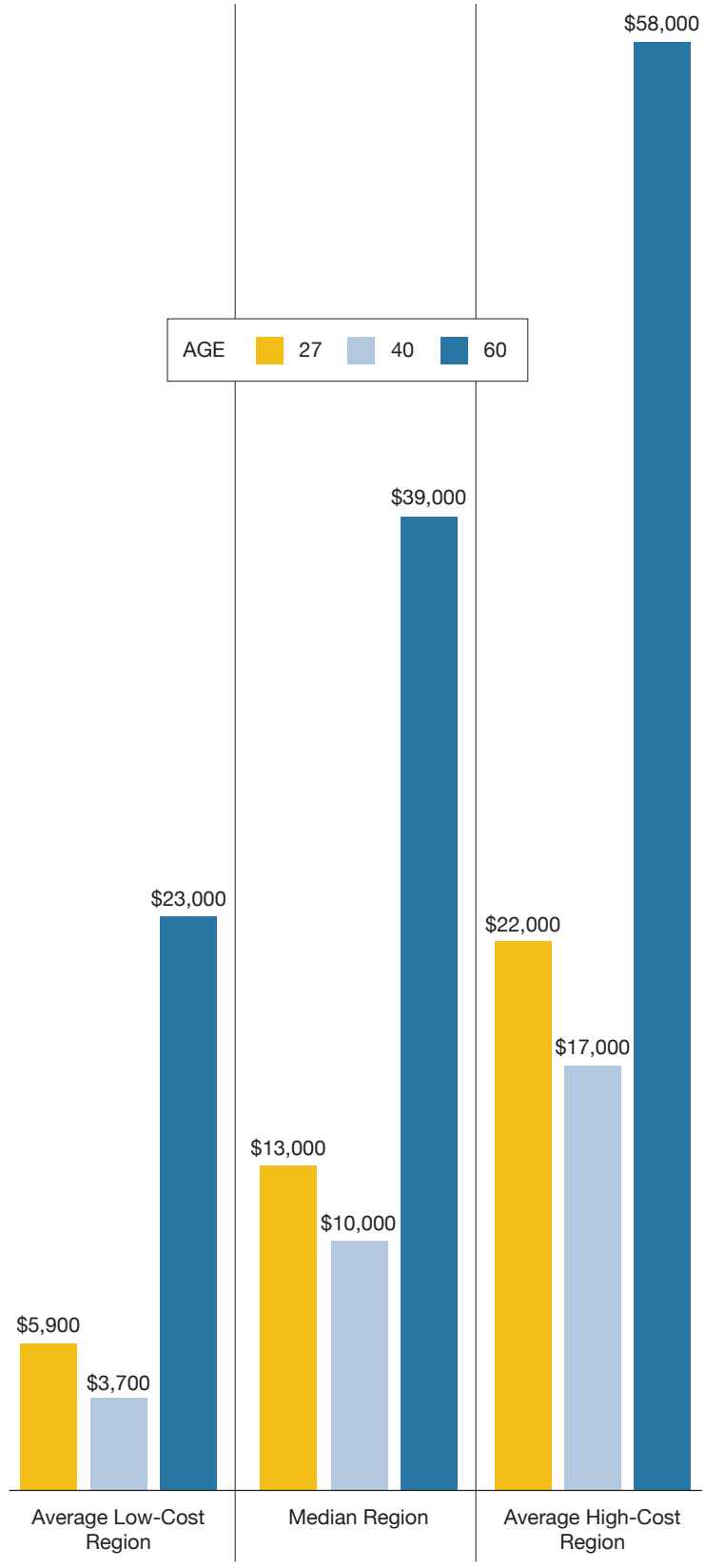
The OACT report, completed about three weeks after the CBO's analysis found that "only" 13 million Americans would become newly uninsured under the AHCA, but this conclusion was based in part on its modeling that the coverage for those remaining in the individual market would be significantly less generous on average than under the ACA. The OACT report found that the "estimated average cost-sharing amounts are projected to be roughly 61 percent higher than the ACA baseline in 2026." This means, for example, that ***using current ACA benefit designs, a "Silver Tier" plan would move from having an annual deductible of $3,000 to an annual deductible of over $7,250***.

These increases in enrollee cost-sharing demonstrates the trade-offs of pursuing lower premiums with decreased financial subsidies and puts into question whether such coverage is meaningful.

Analyzing "No Cost" Coverage Using AHCA Subsidies to Affordability Help Access

One way to assess the value of the AHCA's subsidies is through the lens of what consumers could get if they did not contribute towards their premium, but the subsidy was used to

Figure 1
Deductible and Maximum Out-of-Pocket Costs by Age and Region



provide people coverage through auto-enrollment. Analysts have proposed designing health products that use the tax credit amounts in the AHCA to set equivalent annual premiums that would result in "free" plans with no monthly premium for enrollees who qualify for the subsidy.[3] While a policy of providing coverage based on what the tax subsidy would buy is not currently part of the House of Representatives' version of the AHCA and would require a change to federal law on the annual limit on cost-sharing to allow for a higher limit or no limit at all, it provides one window of what coverage would be worth under the AHCA.

To be available for purchase with the AHCA subsidies only, these health insurance products would be set at an actuarial value such that enrollees would be paying no monthly premium. The proposal to provide this "free" coverage also assumes that there would be some pre-deductible coverage for "basic and cost-effective medical services" and that deductibles would be set at an "affordable" amount. For the purpose of this analysis, Covered California modeled the amount of the deductible and the likely identical maximum-out-of-pocket (MOOP) depending on their age group and region assuming there was no coverage prior to the deductible being met. To the extent there was pre-deductible coverage — the deductible would be higher. Additionally, these plans could exclude coverage for major service categories such as drugs or inpatient care in states that have waived EHB requirements. This analysis summarizes what those products would look like depending on the age, income and where different consumers live.

Findings

For this analysis, we considered nine different age and region scenarios with expected annual premiums under the AHCA (using the 5:1 age band ratio), AHCA tax credit amount ($2,000, $3,000, $4,000), and the estimated deductible/MOOP level required for the subsidized plan to be available with no monthly premium for the enrollee (see Table 1. Calculation of Possible Deductible/MOOP Products Resulting from AHCA Tax Credits). Note that there is a "cliff" with the AHCA subsidies where cost-sharing increases as enrollees age into the higher end of their age band and then move into the lower end of the next age band. This means a 40-year-old (who is at the lower end of the age band for that subsidy) has a lower deductible than the 27-year-old who is well above the youngest age for that age band (namely, age 21).

For the median-cost counties, deductibles are high for the 27-year-old and the 40-year-old — roughly double the limits under the ACA. But for the 60-year-old, the deductible/MOOP of $39,000 for the median cost region would mean coverage would be functionally meaningless — getting virtually any care would be the personal responsibility of the individual.

More striking is the extremely wide variation in deductibles by age and by region, ranging for a 40-year-old from a low of $3,700 in a low-cost region and based on the "age cliff" of the subsidy, to $10,000 to $13,000 for enrollees under 40 years old in a medium-cost region, to $58,000 for an older enrollee in a higher cost region (See Figure 1. Deductible and Maximum Out-of-Pocket Costs by Age and Region).

Low premium counties are generally urban areas where there is more insurer and provider competition. High premium counties are more likely to be rural, with monopoly providers (who typically are more expensive) and few insurers.*

* This analysis groups counties into low, medium and high premium cost regions based on average second lowest Silver premiums. Based on enrollment in the federally-facilitated marketplace, about 60 percent of enrollment is in "low" premium counties, 21 percent in medium and 19 percent in high.

Table 1
Calculation of Possible Deductible/MOOP Plan Resulting From AHCA Tax Credits

Age	27-Year-Old			40-Year-Old			60-YEAR-OLD		
Region (High, Median, Low Cost)	Low-cost Region	Median Region	High-cost Region	Low-cost Region	Median Region	High-cost Region	Low-cost Region	Median Region	High-cost Region
County Example (annual premium taken from this county)	Union, OH		Atchison, MO	Delaware, OH		Hardee, FL	Polk, IA		Washington, ME
AHCA Premiums in 2020 Proxy for health care costs in the region[4]	$3,240	$4,370	$5,730	$4,280	$5,750	$7,430	$11,560	$16,210	$21,090
AHCA Tax Credits Cost of the annual premium for a no-premium, subsidized plan (paid with public funding)	$2,000	$2,000	$2,000	$3,000	$3,000	$3,000	$4,000	$4,000	$4,000

These findings show that while the concept of providing "no cost" coverage based on what a subsidy can buy may appear to be a way to ensure more Americans get health coverage, it raises a number of issues that warrant further review, specifically:

- Proposed AHCA subsidy levels are likely insufficient for many potential enrollees, particularly at older ages, and are structured with a series of "steps" that dramatically vary their impact: The varying subsidy amounts in the AHCA ($2,000 to $4,000) do not mirror the same rating ratio of 5:1 from younger to older enrollees, so younger enrollees will benefit more from the $2,000 subsidy compared to older enrollees, whose subsidy is $4,000 while their premiums are proportionally far higher than are those for younger enrollees. Additionally, enrollees at the higher end of each age group will see their deductible/MOOP increase dramatically, only to have it fall again when they age into the next age bracket.
- Failure to adjust subsidies for the wide variation in premiums across different states and across regions within states means that those differences will have dramatic effects on coverage and what coverage entails from a consumer perspective. Due to the variation in health care costs, a $3,000 premium in Delaware, Ohio will go much further than $3,000 in Hardee, Florida. Because insurers seeking to offer "no cost coverage" would

need to adjust the actuarial value in each location in order to rate according to the subsidy amount, the coverage levels in high-cost regions will be very low. Under a no-cost coverage structure, a great majority of enrollees will pay out-of-pocket for all health care expenses without their coverage kicking in.

- Enormously high deductible levels for some cohorts of enrollees, would potentially make no-premium plans virtually worthless. Many enrollees who find themselves in coverage without paying a monthly premium will discover very high cost-sharing when they go to use their coverage. Particularly for low and middle-income enrollees, deductibles in the tens of thousands of dollars, which are well above the annual cost-sharing limits stipulated in the ACA, would render the cost of obtaining care simply unaffordable and will likely result in forgone care, medical bankruptcy and uncompensated care for hospitals and providers.
- Some medical services may not count towards the high deductible. In addition to the challenge of meeting the out-of-pocket costs before the deductible is satisfied — that could be from $10,000 to as high as $39,000 — some types of care may not be covered at all and may not count towards the deductible. Because the AHCA provision allows states to waive some of the EHBs, would allow for certain categories of benefits to be excluded from coverage. This means that an individual seeking cancer treatment might be able to count their outpatient visits towards the deductible, but not prescription drugs. Or someone experiencing a major injury might be able to count their hospital bill towards the deductible but not their physical therapy or in-home care.

Methodology

To determine what a plan would look like for varying age groups and regions of the country, this analysis simplified the projected enrollee cost-sharing to the level of deductible and matched it to the maximum out-of-pocket (MOOP) amount. Thus, under this framework, the enrollee would be responsible for 100 percent of costs up to the deductible/MOOP and the insurer would pay 100 percent of the costs above that amount — subject to the care being delivered through in-network contracted providers. As noted earlier, the authors of the concept of using "no cost" plans to promote automatic enrollment into health care, proposed having standardized benefits that would both include coverage on a "pre-deductible" basis of some basic services AND that they would want the products to have "an acceptable deductible." This analysis assumes that no costs are covered prior to the deductible. Any pre-deductible coverage would raise the costs of the deductible — which already is challenged under the current AHCA subsidy levels to fund coverage that would have deductibles anywhere close to "acceptable" levels.

Table 2
AHCA Cost-Sharing by Age Group Under 'Free' Plans

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

We assumed that any ACA limitations on maximum deductibles or MOOPs would not apply. Under this model, no copays or other cost-sharing features are used. To the extent a benefit design provided for some cost-sharing before the deductible/MOOP is met, the deductible/MOOP would be higher.

To show the regional variation in health care costs and premium rates, we used premium costs previously estimated by the Kaiser Family Foundation under the ACA and AHCA in 2020. We also selected the average annual premiums for a low-cost region and high-cost region, and calculated the median premium to demonstrate the differing levels of cost-sharing by location using the flat-dollar subsidy amount.

We used the CMS 2017 open enrollment plan selection data[5] and the revised 2018 actuarial value calculator[6] and referenced the Silver/Combined continuance table, which represents normalized costs for both medical services and prescription drugs, to perform a manual calculation for the deductible/MOOP for each age and region scenario. We applied the representative premium amounts from the low, median and high regions and the subsidy amounts allowed under the AHCA to determine the consumer cost-sharing for the three different ages in the three regions.

About Covered California

Covered California is an independent part of the state government whose job is to make the health insurance marketplace work for California's consumers. It is overseen by a five-member board appointed by the governor and the legislature. For more information about Covered California, please visit www.CoveredCA.com.

[1] Congressional Budget Office, cost estimate for H.R. 1628 American Health Care Act of 2017, as passed by the U.S. House of Representatives on May 4, 2017 (May 24, 2017). https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf

[2] Spitalnic, Paul, Centers for Medicare & Medicaid Services Office of the Actuary, memorandum "Estimated Financial Effect of the 'American Health Care Act of 2017'" (June 13, 2017). https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/AHCA20170613.pdf

[3] Chen, Lahnee and Capretta, James. "The Senate Should Build Automatic Enrollment Into Health Reform. Here's How." Health Affairs Blog. (June 5, 2017). http://healthaffairs.org/blog/2017/06/05/the-senate-should-build-automatic-enrollment-into-health-reform-heres-how/

[4] Tax Credits in 2020 for single coverage under the Affordable Care Act vs. the American Health Care Act. The Henry J. Kaiser Family Foundation. (April 27, 2017).

[5] 2017 Marketplace Open Enrollment Period Public Use Files. The Center for Consumer Information & Insurance Oversight (CCIIO), Centers for Medicare & Medicaid Services (CMS). https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html

[6] Revised 2018 Actuarial Value Calculator. The Center for Consumer Information & Insurance Oversight (CCIIO), Centers for Medicare & Medicaid Services (CMS). (April 13, 2017). https://www.cms.gov/cciio/