Research

The Health Care Choices Proposal

DOUGLAS HOLTZ-EAKIN, CHRISTOPHER HOLT | OCTOBER 22, 2020

In October, the Health Policy Consensus Group released a health care reform plan called "The Health Care Choices Proposal."[1] The stated purpose of this plan, referred to in this report as the Proposal, is the expansion of choice, lowering of costs, and protection of the vulnerable via safety nets and personalized care. One of the Proposal's key features is a Health Care Choices Formula Grant, which this estimate assumes is allocated to the states beginning in 2022, giving states resources and authority to design their own safety net programs and other reforms aimed at making insurance more affordable. The Center for Health and Economy (H&E) scored a previous version of this Proposal in October 2018.[2] This updated score accounts for changes to the Proposal's formula grant, explicit access to health savings account (HSA) funds, and provider access and health innovation changes. All impacts projected in this report are relative to H&E's 2020 baseline.[3] As with all projections, the estimates are associated with some degree of uncertainty.

Key Findings:

- **Premium Impact:** The Proposal is projected to decrease the cost of premiums for private individual market health insurance coverage. Silver plans would see the largest impact, as premiums would decrease by 18 to 24 percent beginning in 2022 relative to the baseline.
- **Coverage Impact:** The Proposal is projected to result in nearly 4 million more people purchasing insurance by 2030, with enrollment holding steady earlier in the budget window. The Proposal also results in more people enrolling in private coverage versus public insurance over the same period.
- **Medical Productivity Index:** The Proposal would lead to 17 percent increase in the medical productivity index by 2030.[4]
- **Provider Access Index:** The Proposal would lead to a 8 percent increase in the provider access index by 2030.[5]
- **Budget Impact:** When the H&E baseline is used to determine the yearly Health Care Choices Grant, the Proposal would decrease federal spending by $36 billion from 2022 to 2030.

Analysis

This analysis uses a microsimulation model developed for use by H&E. The model employs micro-data available through the Medical Expenditure Panel Survey to analyze the effects of health policies on the health insurance plan choices of the under-65 population and interpret the resulting impact on national coverage, average insurance premiums, the federal budget, and the accessibility and efficiency of health care.

The Proposal's provisions would take effect on January 1, 2022. Where the Proposal's formula grant provision lacks the necessary details, H&E drew on amendment LYN17744—offered by Senators Lindsey Graham and Bill Cassidy during consideration of the American Health Care Act (H.R. 1628) in the 115th Congress—to make assumptions because of its similarities with the Proposal.[6] The following provisions from the Proposal

and subsequent assumptions are included in this score.

- The Proposal grants states broad authority to reform their individual health insurance markets, provided they offer premium assistance to low-income individuals and "better options for care" for people with pre-existing or chronic illnesses and high health care costs.
- The Proposal repeals the Affordable Care Act's (ACA) subsidies to states for enrolling childless, non-disabled, working-age adults in Medicaid as well as repeals the entitlements to subsidies for individual health insurance premiums and cost-sharing reduction subsidies, and it redirects these resources as formula grants, known as Health Care Choices Grants**,** to the states, coupled with new flexibility and incentives.
- At least 50 percent of the formula grant goes toward supporting people's purchase of private health coverage.
- At least 50 percent goes to provide coverage for low-income people (the two categories will overlap).
- A portion of the grant goes to offset the costs of high-risk patients to avoid driving up premiums for everyone else in the market.
- Anyone eligible for financial assistance under the grant can take the value of their premium assistance to purchase a private plan.
- Funds to finance the grants are based upon spending, as of a fixed date, on ACA subsidies (both tax credits and cost-sharing payments) and Medicaid expansion.
- States receive regulatory relief from certain federal mandates imposed by the ACA, allowing states greater flexibility.
- Essential health benefit mandates are replaced with more flexible standards used in other government health programs.
- A single Health Care Choices Grant of a fixed amount is set aside for the states, detailed in Table 1 below.

Table 1. Health Care Choices Grants by Year (Billions)*

Year	Amount
2022	$85
2023	$88
2024	$94
2025	$100
2026	$106
2027	$113
2028	$120
2029	$127
2030	$135

*Amounts use H&E's 2020 baseline estimates for the Medicaid expansion population, exchange subsidies, and basic health program.

- The Proposal does not assign allotments for each state, but it does indicate that early in implementation the allotments will be based on each state's ACA-related spending. Over time, the allotment will be

increasingly based on a state's proportion of low-income residents (see Table 2).

- ACA-related spending is any spending related to the individual market (subsidies, basic health program, etc.) and the spending on the Medicaid expansion population.

Table 2. Allocation Formula of Health Care Choices Grant

Year	Percent of Health Care Choices Grant Received
2022	= 2021 proportion of ACA-Related Spending
2023	=90% of 2022 proportion + 10% of low-income proportion
2024	=80% of 2023 proportion + 20% of low-income proportion
2025	=70% of 2024 proportion + 30% of low-income proportion
2026	=60% of 2025 proportion + 40% of low-income proportion
2027	=50% of 2026 proportion + 50% of low-income proportion
2028	=40% of 2027 proportion + 60% of low-income proportion
2029	=30% of 2028 proportion + 70% of low-income proportion
2030	=20% of 2029 proportion + 80% of low-income proportion

- The three-to-one age-based community rating requirement on premiums is removed. This score assumes that all states that did not have age-based community rating prior to the enactment of the ACA have a new age-rating of five to one reflecting how health costs vary by age.[7] It further assumes that states with more restrictive age-rating ratios retain them.
- The single risk pool requirement for the individual market is removed.
- Individuals receiving subsidies can apply them to any private coverage option of their choice, including short-term, limited-duration insurance (STLDI) H&E assumed these plans are defined, per current federal rules, as having a duration of 364 days and being renewable for up to 3 years at the discretion of the issuer.
- The Proposal allows states to permit premium discounts for individuals who maintain continuous coverage. For modeling purposes, H&E assumed a 5 percent premium discount for those continuously enrolled in health insurance is implemented in the year 2022.
- The Proposal gives the states a certain amount of freedom in the way formula grant funds can be used. H&E made assumptions on how states would use these funds based on the laws in the states as of October 2020. Table 3 below illustrates these state policies.

- It was assumed that states that both have a state exchange and expanded Medicaid under the ACA would seek to retain their current law as much as possible.
- States that have only expanded Medicaid would seek to retain their Medicaid expansion while utilizing the rest of their Health Care Choices Grant funds through a combination of tax credits and reinsurance. While the Proposal stipulates that a variety of risk mitigation strategies are eligible for use with state allotments, the model assumed that all states employ reinsurance as a risk mitigation strategy.
- The ACA tax-credit structure remained in place for each state with a state-based exchange.
- It was assumed that states that did not create an exchange or expand Medicaid would only use their allotment for reinsurance and tax credits.

Table 3. State Policies as of October 2020

State	State Exchange and Expansion	Medicaid Expansion Only	State Exchange Only	Neither
Alabama				X
Alaska		X		
Arizona		X		
Arkansas		X		
California	X			
Colorado	X			
Connecticut	X			
Delaware		X		
District of Columbia	X			
Florida				X
Georgia				X
Hawaii		X		
Idaho	X			
Illinois		X		
Indiana		X		
Iowa		X		
Kansas				X
Kentucky		X		
Louisiana		X		
Maine		X		
Maryland	X			
Massachusetts	X			

Michigan		X		
Minnesota	X			
Mississippi				X
Missouri		X		
Montana		X		
Nebraska		X		
Nevada	X			
New Hampshire		X		
New Jersey	X			
New Mexico		X		
New York	X			
North Carolina				X
North Dakota		X		
Ohio		X		
Oklahoma		X		
Oregon		X		
Pennsylvania	X			
Rhode Island	X			
South Carolina				X
South Dakota				X
Tennessee				X
Texas				X
Utah		X		
Vermont	X			
Virginia		X		
Washington	X			
West Virginia		X		
Wisconsin				X
Wyoming				X

Note: The states included in Medicaid expansion have begun or planned to implement their programs as of October 2020. For example, Nebraska implemented expansion beginning October 2020, while Oklahoma and Missouri will implement expansion as of July 2021. All three are included in this analysis as having expanded Medicaid.

- The Proposal requires that states use a portion of the Health Care Choices Grant for a risk-mitigation program. In accordance with this requirement, a reinsurance program is implemented for every state in this modeling. H&E assumed that the government would make reinsurance payments to insurers for all the claims per beneficiary incurred above a specific threshold. The threshold would be equal to the 90th percentile of beneficiaries ranked by total claims.

Premium Impact

H&E health insurance premium estimates are based on five plan design categories offered in the individual market exchanges: Platinum, Gold, Silver, Bronze, and catastrophic. Under current law, the cost-sharing designs of the four metallic categories correspond to approximate actuarial values: 90 percent, 80 percent, 70 percent, and 60 percent, respectively. Catastrophic coverage plans refer to health insurance plans that reimburse medical expenses only after members meet a high deductible—a maximum of $8,150 for an individual in 2020. Under current law, catastrophic plans have roughly a 50 percent actuarial value. This report also includes STLDI plans in the catastrophic category, however, so the catastrophic category represents a range of actuarial values and plan designs. All premium estimates reflect average health insurance prices paid, without regard to federal subsidies.

Table 4 below presents the estimated premiums for each category between 2022 and 2030.

Table 4. Average Annual Premiums in the Individual Market

		2022	2023	2024	2030
Single Coverage	Platinum	7,500	7,800	8,100	10,100
	Gold	6,800	7,000	7,300	9,200
	Silver	6,200	6,500	6,700	8,400
	Bronze	6,200	6,400	6,600	8,200
	Catastrophic	5,300	5,500	5,700	7,300
Family Coverage[1]	Platinum	14,900	15,300	15,900	19,600
	Gold	13,700	14,100	14,500	17,900
	Silver[2]	13,600	14,000	14,500	17,900
	Bronze	12,900	13,300	13,700	16,900
	Catastrophic	11,600	12,000	12,400	15,500

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

[2]Silver plans offered to low income households receive cost-sharing benefits that alter the effective premium relative to un-assisted Silver plans.

H&E estimates that the Proposal would eventually lead to lower health insurance premiums in all categories for both single and family coverage relative to the 2020 baseline projection, with the largest decreases occurring among Silver plans.

The decrease in premiums can be attributed to several changes. Current law mandates that insurers offer a Silver plan with reduced cost-sharing for consumers with incomes at or below 250 percent of the federal poverty level. In exchange for offering plans with reduced cost-sharing, insurers were to receive cost-sharing reduction payments (CSRs) from the federal government to ease the burden of providing extra benefits; they are currently not receiving CSRs, however, resulting in upward pressure on premiums (especially Silver premiums). Reintroducing CSRs or removing the requirement on insurers to sell plans with cost-sharing reductions would lead to significant downward pressure on Silver premiums.[8] H&E assumes that states either fund CSRs to benchmark Silver plans or remove the requirement to offer Silver plans with CSRs.

Under current law, health insurance plans are only able to alter rates based on three factors—geographic location, age (a maximum ratio of 3:1), and tobacco use (a maximum ratio of 1.5:1)—and are explicitly prohibited from taking into account any information on expected medical expenses.

Since insurance companies still need to cover the cost of insuring lives, these actuarial pricing restrictions lead to more people paying close to average premiums. Intuitively, high-risk individuals who would otherwise pay higher than average premiums benefit from such restrictions, leading those individuals to gain coverage in higher numbers. Similarly, some low-cost individuals, for whom a close-to-average premium is a bad value, may drop insurance coverage. These fluctuations in the pool of insured are likely to cause average premiums to rise. The Proposal is projected to lower average premiums compared with current law when states loosen these restrictions.

The Proposal requires states to use a portion of their allotment to establish a risk-mitigation program (e.g., high-risk pools, “invisible” high-risk pools, risk adjustment, reinsurance). Reinsurance, for example, would provide payments to insurers that enroll high-cost beneficiaries, thereby offsetting some of the risk that insurers take on for enrolling such beneficiaries. In this analysis, it is assumed that states would establish reinsurance programs to achieve risk-mitigation through which insurers would receive payments for the costs they incur for beneficiaries in the 90th percentile of expenses. H&E expects this reinsurance to be another provision that puts downward pressure on premiums for states.

The introduction of STLDI plans would also affect premiums.[9] As STLDI plans pull younger and healthier consumers out of traditional health insurance plans, they would bifurcate the marketplace, putting upward pressure on the premiums of other plans as insurers seek to mitigate the costs of a less healthy risk pool. The premium effects of STLDI plans would be marginal, however, as the loosening of age bands, reinsurance, and tax credits reduce the cost of traditional insurance, thus making STLDI plans less appealing.

Table 5. Change in Average Premiums in the Individual Market

		2022	2023	2024	2030
Single Coverage	Platinum	-11%	-16%	-16%	-18%
	Gold	-11%	-13%	-15%	-18%
	Silver	-24%	-17%	-18%	-24%
	Bronze	-12%	0%	-2%	-6%

Catastrophic	8%	26%	25%	17%	
Family Coverage[1]	Platinum	-11%	-17%	-18%	-20%
	Gold	-16%	-22%	-23%	-25%
	Silver[2]	-24%	-19%	-21%	-27%
	Bronze	-16%	-15%	-15%	-16%
	Catastrophic	10%	20%	18%	15%

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

[2]Silver plans offered to low income households receive cost-sharing benefits that alter the effective premium relative to un-assisted Silver plans.

Coverage Impact

H&E insurance coverage estimates reflect health insurance choices for the under-65 population. H&E estimates that the Proposal would result in slight increases in the insured population, with nearly 4 million more insured in the year 2030 relative to the 2020 baseline projection. Table 6 below shows the overall projected insurance levels.

Table 6. Health Insurance Coverage (Millions)

		2022	2023	2024	2030
Individual Market*		17	16	16	14
	Health Insurance Marketplace	12	11	11	10
	Other Non-Group Insurance	5	5	5	4
Employer-Sponsored Insurance		157	158	158	161
Medicaid		66	66	66	67
Other Public Insurance[1]		5	5	5	6
Total Non-Elderly Population		**274**	**275**	**275**	**276**
Total Insured[2]		**245**	**245**	**246**	**247**
Uninsured[2]		**29**	**29**	**29**	**29**
Percent Uninsured		**11%**	**11%**	**11%**	**10%**

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

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

* Individual Market and Total Insured numbers may not equal the sum of other sub-categories due to rounding.

The projected increase in the number of insured individuals is primarily a result of a decrease in Medicaid enrollment. The decrease in Medicaid enrollment is offset by increases in enrollment in the individual market. H&E expects a large increase in catastrophic coverage, as consumers could use tax credits to that end and could also purchase cheaper STLDI plans. These changes combined with lower overall premium decreases would lead

to 4 million more enrolled in the non-group marketplace by 2030.

Table 7. Change in Coverage Estimates (Millions)

		2022	2023	2024	2025	2026	2025	2026	2027	2030
Individual Market		3	3	3	2	1	1	3	3	4
	Health Insurance Marketplace	3	3	3	2	1	2	3	3	4
	Other Non-Group Insurance	0	0	1	0	0	-1	0	0	0
Employer-Sponsored Insurance		-1	0	0	2	1	1	2	3	3
Medicaid		-3	-3	-3	-2	-2	-3	-2	-2	-3
Other Public Insurance		0	0	0	0	0	0	0	0	0
Total Insured in 2020 Baseline		245	245	244	245	245	246	244	243	243
Total Insured in Proposal		245	245	246	246	246	246	247	247	247

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

Productivity and Access

In an attempt to evaluate access and productivity in the health care system, H&E estimates the Medical Productivity Index and the Provider Access Index. Health insurance plan designs are associated with varying degrees of access to desired physicians and facilities, as well as incentives that promote or discourage efficient use of resources. H&E estimates each index by attributing productivity (i.e. efficiency) and access scores to the range of plan designs available and then using the changes in plan choices to project the evolution of health care quality. These scores are provided in Tables 8 and 9 below.

Table 8. Medical Productivity Index

		2022	2023	2024	2025	2026	2030
Individual Market		3.1	3.1	3.1	3.2	3.2	3.4
	Marketplace	3.0	3.1	3.1	3.2	3.2	3.4
	Other Non-Group Insurance	3.1	3.1	3.1	3.2	3.2	3.4

Table 9. Provider Access Index

		2022	2023	2024	2025	2026	2030
Individual Market		3.0	3.0	3.0	3.0	3.0	3.1
	Marketplace	3.0	3.0	3.0	3.1	3.1	3.2

	Other Non-Group Insurance	2.9	2.9	2.9	2.9	2.9	2.9

H&E expects the medical productivity index to increase relative to the 2020 baseline projection as a result of the Proposal, as Table 10 below demonstrates. The ability for consumers to use subsidies to enroll in catastrophic plans would substantially increase enrollment in those plans. H&E projects that a higher proportion of consumers would purchase higher cost-sharing plans, which drive higher medical productivity. By 2030, the medical productivity index would increase slightly relative to conditions under current law.

Simultaneously, H&E expects the provider access index to change as a result of anticipated regulatory and health insurance product changes deriving from the Proposal. For example, the Proposal's changes in insurer products lead to better quality network choices, provider access would demonstrably improve. Likewise, high-deductible health plans increasingly have access to national provider plan choices, which will increase access. With respect to the impact of the Proposal, an 8 percent increase in the provider access index is expected by 2030, as Table 11 shows.

Table 10. Change in Medical Productivity Index

		2022	2023	2024	2025	2026	2030
Individual Market		13%	14%	14%	14%	15%	17%
	Marketplace	21%	22%	22%	22%	22%	25%
	Other Non-Group Insurance	2%	2%	3%	3%	4%	6%

Table 11. Change in Provider Access Index

		2022	2023	2024	2025	2026	2030
Individual Market		**10%**	**9%**	**9%**	**8%**	**8%**	**8%**
	Marketplace	13%	12%	11%	10%	9%	9%
	Other Non-Group Insurance	4%	4%	4%	4%	4%	4%

[1] Productivity and access estimates refer only to the Individual Market, Medicaid, and under-65, non-disabled population.

Budgetary Impact

H&E projects that the Proposal would lead to a net decrease in budget deficit of $36 billion relative to the current H&E baseline from 2022 to 2030. While the Health Care Choices Grant to the states is meant to be budget neutral, H&E expects actual state spending to be less than the Health Care Choices Grant as a result of state caution and the difficulty involved in making enrollment projections. The decrease in Medicaid enrollment discussed above would lead to decreases in Medicaid spending, which further decreases net spending relative to H&E's 2020 baseline. Incentives to expand HSA accounts in the Proposal will yield $133 billion in funds used from 2022 to 2030.

Table 12. Change in Budgetary Impact Estimates Relative to 2020 Baseline (Billions)

			2022	2023	2024	2025	2026	2027	2028	2029	2030	2022-2030
Uses of Funds[2]												
	Health Insurance Marketplace											
		Cost Sharing Benefits	1	1	1	1	1	1	1	1	1	8
		Premium Tax Credits	60	62	63	65	63	79	89	91	91	685
		HSA accounts	11	11	12	13	14	16	18	19	19	133
		Reinsurance Payments	11	11	11	11	12	12	12	12	12	105
Source of Funds												
	Medicaid		-76	-79	-85	-91	-97	-103	-110	-117	-125	(884)
	Other		-8	-9	-9	-9	-9	-9	-10	-10	-10	(83)
	Subtotal		**-2**	**-2**	**-6**	**-9**	**-17**	**-5**	**0**	**-5**	**-13**	**(36)**
Net Budgetary Impact[3]			**2**	**2**	**6**	**9**	**17**	**5**	**0**	**5**	**13**	**36**

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

[2] Positive values denote increases in spending; negative values denote decreases in spending.

[3] Positive values denote surplus; negative values denote deficit.

It should be noted that the example allotment amounts used in this analysis are based on H&E spending projections, thus resulting in significant budgetary impacts. This is discussed further in the "Uncertainty in Projections" section below.

Uncertainty in Projections

H&E uses a peer-reviewed micro-simulation model of the health insurance market to analyze various aspects of the health care system.[10] As with all economic forecasting, H&E estimates are associated with substantial uncertainty. While the estimates provide a good indication on the nation's health care outlook, there are a wide range of possible scenarios that can result from policy changes, and current assumptions are unlikely to remain accurate over the course of the next 10 years. The Proposal presents many unique challenges that produces substantial uncertainty.

The most significant source of uncertainty stems from state behavior. For simplicity, and based on past behavior, H&E assumed four different state scenarios, but presumably states would employ a wider range of policy combinations. As the number of possible policies implemented at the state level are various, so are the number of possible outcomes, as it is likely that states implement their policies with varying levels of success. For example, the Proposal states that a portion of the Health Care Choices Grant money must be used to offset the costs of high-risk individuals. H&E assumed that each state would implement a reinsurance program to this end, but states could also seek to achieve the same goal through the use of high-risk pools, risk corridors, or some other risk-mitigation mechanism.

H&E did not make assumptions about whether states would craft policies that would require additional state funding. It is possible that states would use their own funds to supplement the Health Care Choices Grant in order to implement the non-group market policies they design. Some states did so before the ACA, and some currently are pursuing this avenue with various proposed and approved section 1332 waivers.[11] It is likely that states that choose to do this would further decrease premiums and increase enrollment.

The Health Care Choices Grant amount is another source of uncertainty. The Proposal uses current projections of ACA-related spending in order to budget the next 10 years of the Health Care Choices Grant. Presumably, Congress would use the baseline estimates of the Congressional Budget Office (CBO) in order to set the budget. H&E makes different assumptions in its baseline, however, that would lead to significantly less federal funding for state Health Care Choices Grant spending.[12] This report presents the scenario where H&E's baseline estimates of ACA spending are used to budget the Health Care Choices Grant amounts. The main reason for using the H&E baseline is that the Proposal seeks to be budget neutral by matching the Health Care Choices Grant amount with projected spending. If CBO's current baseline were to be used for this report, the Proposal would increase spending relative to H&E's baseline and enrollment levels would likely be higher under such a scenario.

Aside from the assumptions made with regard to the Health Care Choices Grant amount, the Proposal would likely be implemented under a future CBO baseline that differs from CBO's current baseline. The Health Care Choices Grant amounts for such proposal would be a moving target until the time of its implementation.

The Proposal also includes the Trump Administration's final rule on STLDIs. The largest source of uncertainty with regard to STLDIs stems from state behavior. Several states have laws in place that would negate the effects of the proposed rule in their states. It is possible that other states would follow suit, and more regulations at the state level could further suppress STLDI enrollment, which would have implications for marketplace premiums

and enrollment. A more thorough discussion of the uncertainties surrounding STLDI's can be found at healthandeconomy.org.[8]

Finally, the national effects on premiums are a substantial source of uncertainty. As discussed above, many policy assumptions in this report combine to put significant downward pressure on premiums. The magnitude of the premium changes, however, is largely determined by state-specific policy decisions. H&E's assumptions on age-based community rating, premium discounts for continuously enrolled individuals, and reinsurance programs are all likely to differ from state to state with various premium effects. Also, states with poorly written and implemented policies could produce premium increases relative to current law.

[1] https://www.healthcarechoices2020.org/

[2] https://healthandeconomy.org/the-health-care-choices-proposal/

[3] https://www.americanactionforum.org/research/health-and-economy-baseline-estimates-2/

[4] http://dev-health-economy.pantheonsite.io/models/medical-productivity-index/

[5] http://dev-health-economy.pantheonsite.io/models/provider-access-index/

[6] https://www.cassidy.senate.gov/imo/media/doc/LYN17752.pdf

[7] https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf

[8] http://healthandeconomy.org/reinsurance-and-cost-sharing-reductions-estimates/

[9] http://healthandeconomy.org/the-proposed-modifications-to-short-term-limited-duration-insurance-plans/

[10] Parente, S.T., Feldman, R. "Micro-simulation of Private Health Insurance and Medicaid Take-up Following the U.S. Supreme Court Decision Upholding the Affordable Care Act." Health Services Research. 2013 Apr; 48(2 Pt 2):826-49.

[11] A list of these waivers can be found at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html

[12] H&E does not assume Medicaid expansion take-up by the states in its baseline. Therefore, Medicaid spending and enrollment projected by H&E is noticeably less than that of CBO, roughly $160 billion over the ten-year budget window.