The American Health Care Act … The CBO's Assessment

- The Congressional Budget Office (CBO) estimates that the Republicans' proposed *American Health Care Act (AHCA),* relative to the existing path under Obama's *Affordable Care Act (ACA)*, will trim the fiscal 2017 (FY17)[1] deficit by $0.8 billion, then widen the FY18 and FY19 shortfalls by $24 billion and $33 billion, respectively, before narrowing annual deficits by increasing amounts through FY26 (chart 1).

- From FY17 to FY26, the *AHCA* is expected to cut direct federal spending by $1.2 trillion and revenues by $0.9 trillion, shrinking the cumulative deficit by $337 billion.

- The number of uninsured Americans under age 65 is expected to climb under the *AHCA* by 14 million in calendar 2018, and by 24 million by 2024. By 2026, with 28 million uninsured already expected under the *ACA,* the total number of uninsured would rise to 52 million (chart 2), representing 18.6% of the U.S. population under 65, up from the existing 9.5% share. The Office of Management and Budget, reportedly using CBO methodology, estimates a 26 million rise in the number of uninsured by 2026 with the *AHCA*—17 million from Medicaid, 6 million from the nongroup market, and 3 million from employer-based plans.

- The CBO's report highlights the complexity of the proposed changes and the difficulties in accurately modelling their impact. The probability of unintended consequences is high; elevated uncertainty and transition costs for all stakeholders will be material; required attention to health reform will likely crowd out growth-enhancing initiatives such as tax reform and infrastructure; and State governments will face substantive policy overhauls.

THE FAR-REACHING CONSEQUENCES OF HEALTH CARE REFORM

The *AHCA*, released by House Republicans on March 6th, is the first of three anticipated proposals to modify the *ACA*. The discussion below focuses only on several aspects of this first round of proposed changes, aiming to illustrate the *AHCA*'s broad and significant impact. For example, a number of Internal Revenue Code changes from the *ACA* would be repealed, such as: the surtax on net investment income and the increase in the Hospital Insurance payroll tax rate for certain high-income taxpayers; the *Medical Device Excise Tax;* the annual fee on health insurance providers; and the taxes on over-the-counter and prescription medications. The excise tax on Cadillac health insurance plans would be delayed.

The *AHCA* would eliminate the 'Individual' mandate that levies a penalty on adults who do not obtain health insurance coverage, and the 'employer' mandate that imposes a penalty on large employers who do not provide insurance to a specified standard. The removal of the individual mandate contributes to the CBO's expected near-term rise in the number of uninsured, and young, healthy adults exiting nongroup insurance pools are expected to push up premiums for the

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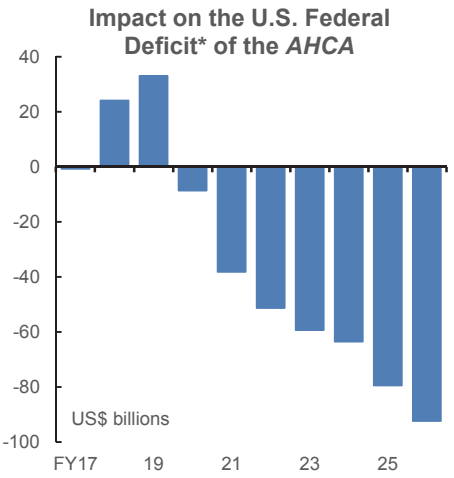
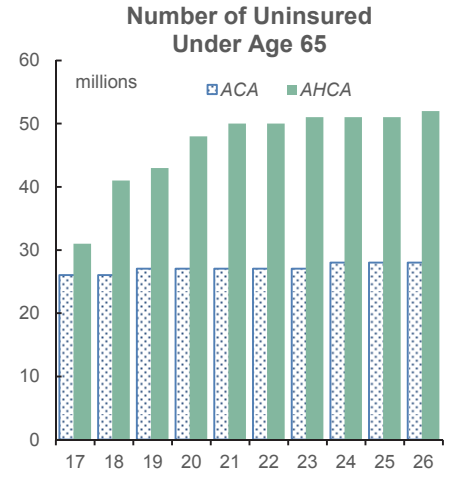
Chart 1



* A postive bar widens the deficit.

Chart 2



Source for charts: Congressional Budget Office.

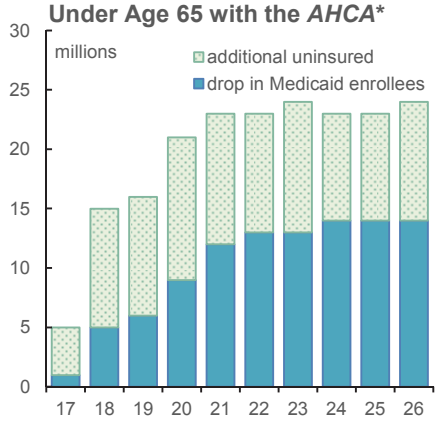
[1] The U.S. federal fiscal year ends September 30th. All dollar data are US dollars.

remaining participants. A partial offset is the *AHCA's* continuous coverage provision which creates a 30% premium surcharge for up to a year in the nongroup or small-group markets if an individual was not covered for more than 63 days in the prior year.

For nongroup health insurance until calendar 2020, existing premium subsidies (refundable tax credits) will be retained to cover a portion of the premium cost for individuals with incomes between 100% and 400% of the Federal Poverty Level. As of 2018, the premium subsidies also will apply to insurance purchased outside of exchanges. Existing cost-sharing subsidies for low-income policy holders to assist with out-of-pocket costs also will exist through 2019.

Chart 3

Rise in the Number of Uninsured Under Age 65 with the *AHCA**



* Relative to forecast number of uninsured under the *ACA*. Source: Congressional Budget Office.

Eliminating the two existing nongroup subsidies through exchanges and related spending saves $673 billion through FY26, while the proposed tax credits as of 2020 for modest-income purchasers of nongroup insurance cost $361 billion, resulting in a cumulative net $312 billion saving to FY26. Existing subsidies vary by a citizen's income and location; the proposed tax credits would be about 60% of the average existing subsidy in 2020, falling to 50% by 2026, and would vary by age, with $2,000 for 25-year olds, rising to $4,000 for residents 60 years or over. This escalation by age reflects the proposed rise in older residents' nongroup premiums from a cap of three times to five times the annual premiums for young adults.

Low-income premium assistance under the *AHCA* should be boosted by the *Patient and State Stability Fund Grants*, beginning in 2018 and ending after 2026 that will allocate $100 billion annually among State governments to cover health needs. As of 2020, the grants are conditional on a State matching 7% of the new federal nongroup funding, rising to 50% by 2026. The resulting drop in premium costs for uncovered low-income residents is expected to encourage insurers' participation. State administrations must now scramble to determine the most effective use of their *Grants* as the federal programs evolve.

Health care differences among States also will widen due to the proposed Medicaid changes. The CBO expects federal funding for Medicaid to fall by $155 billion (-25%) by FY26 relative to the *ACA,* for a total FY17-FY26 saving of $880 billion, as the number of Medicaid enrollees drops by 14 million (-17%) by 2026 (chart 3). The 31 States and the District of Washington that opted under the *ACA* to expand their Medicaid coverage to adults younger than 65 whose incomes are up to 138% of the Federal Poverty Level, cover about half of the eligible population nationwide. The *AHCA* would reduce the federal matching rate for newly eligible adults who enroll after 2019 from 90% of their medical costs to the rate for other enrollees, which varies from 50% to 75% by State and averages 57% nationally. Because individuals cycle in and out of the Medicaid program, the CBO estimates that by the end of 2024, the 90% federal matching rate would apply to less than 5% of the newly eligible adults covered by Medicaid.

A federal per capita cap on Medicaid payments would apply after 2019. Currently, States pay health care providers for their services to Medicaid participants and Washington reimburses each State for a percentage of its outlays. Under the *AHCA*, the average cost of full Medicaid benefits per enrollee in 2016 would be annually indexed by the CPI for medical care services. The latter is forecast to rise 3.7% annually through FY26, less than the 4.4% average annual hikes expected for actual Medicaid costs. This may encourage more efficient delivery, but it also is likely to restrict allowed enrolment and covered services in many States.

OUTLOOK

A relatively stable nongroup market is still projected by the CBO and the Joint Committee on Taxation under the *AHCA*, though they acknowledge the extensive and extended changes proposed and the wide variance in potential responses from federal, state and municipal governments, insurers, employers, health care practitioners, health institutions and individuals. Prior studies by the OECD and others document the risks of embarking on a health care overhaul without stakeholders' full understanding and buy-in. These studies also describe the extensive government resources absorbed in the design and transition phases of health policy overhauls, reinforcing our view that accomplishing the full range of other policy changes proposed by the Trump administration will be inevitably delayed.

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