What Can Consumers Purchase with the Age-Related Tax Credits in the Empowering Patients First Bill?

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Introduction

Several congressional proposals to replace the Affordable Care Act (ACA) feature refundable age-related tax credits for the purchase of nongroup health insurance (Claxton, Rae, and Panchal 2015).[1] These credits would replace the ACA's income-related refundable tax credits (for people with incomes up to 400 percent of the federal poverty level [FPL]) as well as the income-related subsidies reducing nongroup insurance cost-sharing requirements (for people with incomes up to 250 percent of FPL); depending upon the proposal, age-related tax credits could also replace the ACA's Medicaid expansion for people with incomes up to 138 percent of the poverty level. Because fewer people are eligible for tax credits under the ACA than under alternative proposals, the average eligible person receives more financial assistance—that is, unless new proposals include much larger investments of federal dollars, which is extremely unlikely.

People enrolled in Medicaid under the ACA have very low incomes by statute; thus, they would have little to no additional funds to contribute to their health insurance beyond the tax credit provided. Large percentages of those enrolled in nongroup coverage through the ACA's Marketplaces have incomes below 200 percent of FPL (two-thirds of Marketplace enrollees in states with federally facilitated Marketplaces have incomes below 200 percent of FPL; ASPE 2016a), and many of those individuals and families contribute only small portions of their incomes toward their health insurance premiums (percent-of-income caps range from 2.04 to 6.43 percent for this income group in 2017[2]). Payments by Marketplace enrollees with incomes between 200 and 400 percent of FPL can be higher, ranging from 6.43 to 9.69 percent of income in 2017. However, some members of Congress and policy analysts anticipate replacing the ACA's individual mandate with automatic enrollment into health plans costing no more than the proposed age-related tax credits.[3]

Under such a regime, insurers would need to develop and sell products with premiums at or below the amount of the tax credits. This is possible because the proposed alternatives consistently eliminate federal essential health benefit standards, minimum actuarial value (AV) standards, and overall out-of-pocket limits. Low-income individuals who want to use their tax credits to buy insurance likely would be unable to afford more comprehensive coverage.

Elimination of benefit and AV standards, combined with elimination of the risk adjustment program, could make it very difficult for insurers to offer options substantially more comprehensive than what could be purchased for the amount of the credit. Insurers that offered plans with more benefits and lower cost-sharing requirements could be expected to attract enrollees at higher-than-average risk of using significant medical services. Without a mechanism for spreading health care risk across those purchasing different types of coverage, insurers may be reluctant to offer broader coverage that would almost certainly attract higher-cost enrollees.[4] However, it is unclear how long insurers would continue to offer ACA-level insurance policies and how quickly premiums for those policies would become prohibitively expensive for most current enrollees.

But would policies priced at the level of the age-related tax credits be attractive to consumers? The House Republicans' "Better Way" health care plan does not spell out the amounts of age-related tax credits, but the Empowering Patients First proposal by Secretary of Health and Human Services (former congressman) Tom Price does offer specifics. We use the tax credits described in Price's Empowering Patients First bill to model an insurance package that could be purchased by any adult age 18 to 64 for no more than the proposed credit amounts.

Consider the following as a basis for comparison:

1. The ACA's Medicaid coverage for people with incomes below 138 percent of FPL is effectively 100 percent actuarial value coverage.[5] In other words, Medicaid reimburses providers for all of the medical costs incurred by the average enrollee in this income group.
2. The ACA's Marketplace tax credits are pegged to a 70 percent AV (silver) plan, meaning the benchmark plan reimburses 70 percent of health care costs incurred by enrollees on average (calculated over a standard population), and the enrollees pay for the remaining 30 percent of costs out of pocket on average.
3. Large percentages of Marketplace enrollees are also eligible for cost-sharing subsidies that increase the AV of their silver-level policies. In 2016, 57 percent of Marketplace enrollees had plans with an AV of 94 percent, 87 percent, or 73 percent.[6] For enrollees who choose to purchase 60 percent AV (bronze) plans instead of silver plans, the ACA tax credit often pays for the entirety of the premium.

Benefit options are constrained by the levels of the credits proposed in the Empowering Patients First bill. Our main findings are as follows:

- The bill would provide the same tax credit amount to people in each of four age groups: $900 per child; $1,200 per person age 18 to 34; $2,100 per person age 35 to 49; and $3,000 per person age 50 and older. Because insurers would be able to charge higher rates for each year of

increasing age, the amount of coverage a person could buy with the credit would decrease as they age *within an age bracket*.

- The bill does not limit the differential in premiums that insurers could charge for an older adult relative to the youngest adult. We assume 5:1 age rating (i.e., a 64-year-old could not be charged more than five times what an 18-year-old would pay for identical coverage) in our analysis because critics of the ACA's 3:1 age rating restrictions often cite it as an appropriate replacement, and because it closely reflects the actuarial differences in average health care costs between 64- and 18-year-olds.[7] However, the proposal's tax credit for a 64-year-old would only be 2.5 times that for an 18-year-old, and as a result, premiums charged would increase substantially faster than the credit as people age. Consequently, the level of coverage someone could purchase with the credit would decrease significantly with age. If insurers varied premiums by more than 5:1, as was frequently seen in the nongroup market before 2014, the level of coverage that could be purchased with the credit would erode even faster with age.
- A 25 percent AV plan is the most comprehensive coverage that all adults ages 18 to 64 could purchase using no more than the Empowering Patients First tax credits (based on 2016 spending levels). Higher AV plans would not be affordable for people ages 61 to 64 if they used only the amount of the credit. A 34 percent AV plan would be the most generous coverage available to adults age 34 and ages 56 to 60 paying only with their tax credits. For those ages 29 to 33, 47 to 49, and 53 to 55, the most generous plan has an AV of 41 percent. However, our estimates do not account for premium variation by factors other than age (e.g., gender; occupation; duration of coverage; and, for those not maintaining continuous coverage, health status), which would be permitted under the Empowering Patients First bill. Such variation would make coverage at these AV levels substantially more expensive than the value of the tax credits offered for people with higher risk characteristics.
- One illustrative plan that would satisfy the 25 percent AV standard—a single plan all nonelderly adults could buy in 2016 using no more than the Empowering Patients First tax credits—has a $25,000 deductible for single coverage, a $50,000 deductible for family coverage, and $25,000/$50,000 out-of-pocket maximums. It would cover generic drugs only and would exclude outpatient mental health and substance use disorder services, physical therapy, occupational therapy, speech therapy, and rehabilitation services.
- Roughly half of people between the ages of 18 and 64 (those ages 18 to 28, 35 to 46, and 50 to 52) could use their credits alone to purchase coverage with an actuarial value of 47 percent, assuming no other rating factors. One such plan has a single deductible of $6,850 and a family deductible of $13,700, $6,850/$13,700 out-of-pocket maximums, and the same benefit exclusions noted above.

Data and Methods

We relied exclusively on publicly available data to conduct this analysis, including data from federal Marketplace enrollment reports (ASPE 2016a, 2016b), the Robert Wood Johnson Foundation's HIX Compare data, and the 2014 Household Component of the Medical Expenditure Panel Survey (MEPS-HC). We identified a Marketplace silver plan and used it as a starting point for constructing illustrative plans for which premiums did not exceed the tax credit amounts specified in the Empowering Patients First bill ($900 per child up to age 18; $1,200 for people ages 18 to 34; $2,100 for people ages 35 to 49; $3,000 for people ages 50 and older). A more detailed description of our methodology is provided in the technical appendix.

Our risk pool included all current nongroup insurance enrollees (those covered through Marketplace or non-Marketplace coverage under the ACA) as well as a random one-third of those uninsured under current law. We used data from the Medical Expenditure Panel Survey to estimate relative costs by type of insurance coverage and counts by age.[8] These data allowed us to adjust the starting point premium based on the relative age and expense levels of the added population groups.

We analyzed alternative plans by adjusting parameters in the silver starting point plan. Adjustments were made for actuarial value differences, changes in health care service use resulting from differences in cost-sharing requirements and covered benefits, and differences in medical loss ratios.

Although the Empowering Patients First plan would not impose age rating limits on nongroup insurers at the federal level, we calculated premiums for each year of age using 5:1 age bands. We assume a 5:1 age rating curve because it is the most frequently cited approach in discussions of loosening age bands. We do not estimate the effects of additional rating factors that insurers could use, such as gender and occupation, and we do not estimate the effects of a provision in the Empowering Patients First plan that would allow insurers to charge higher premiums based on health status if the applicant had not maintained continuous coverage. In addition, we do not account for the fact that people living in higher medical cost areas would face higher premiums than those living in lower medical cost areas; our estimates reflect national averages. *All of these conditions—wider age rating bands, additional rating factors, and geographic cost differences—would make more people unable to purchase the specified levels of coverage using only the proposed tax credit. Without accounting for these conditions, our estimates represent upper bounds on the generosity of coverage people of different ages could afford using only the tax credits.*

We continued to compute plans with lower AV until we identified a plan that all people ages 18 to 64 in the risk pool could purchase using only their age-related tax credit, assuming that adults ages 18 to 64 were in a single risk pool at each plan level. For each of the plans computed, we recalculated covered health care spending levels and premiums for each year of age and appropriate utilization effects (i.e., lower use of care as cost-sharing requirements increased). We then compared premiums for each year of age to the proposed tax credit for a person of that age to see which adults could buy that plan using only the credit. If adults of any age were unable to purchase the constructed plan with the tax credit

proposed, we reduced the AV of the plan further, recomputed covered expenses and premiums over all those in the pool ages 18 to 64, and checked again.

Results

We analyzed multiple plan alternatives of decreasing AV to find one package that could be purchased by any adult age 18 to 64 for no more than the amount of the tax credit that would be provided to them under the Empowering Patients First bill. These credit amounts are as follows:

- $1,200 for people ages 18 to 34
- $2,100 for people ages 35 to 49
- $3,000 for people ages 50 and older
- $900 per child up to age 18

Table 1 shows illustrative insurance packages that people of different ages could buy in 2016 using only the age-adjusted tax credits in the Empowering Patients First bill. The amount of coverage that can be purchased using only the credit decreases significantly with age but also decreases as one ages within each of the tax credit age brackets, as shown below. Only the last package in table 1, with a calculated AV of 25 percent, satisfies the condition for adults ages 61 to 64. However, most adults could use their credit to purchase a plan with an AV of 47 percent. All adults except those ages 61 to 64 could use their credit alone to purchase a 34 percent AV plan, assuming no other rating factors.[9]

The illustrative 25 percent AV package has a $25,000 deductible for single coverage and a $50,000 deductible for family coverage, with out-of-pocket maximums equal to the deductibles. The plan includes preventive benefits with no cost-sharing requirement but excludes the following benefits: nongeneric drugs, outpatient mental health and substance use disorder care, speech therapy, occupational therapy, physical therapy, and rehabilitation services. Generic-only prescription drug coverage would exclude insulin, chemotherapy, and other drugs without generic alternatives, including many high-cost drugs used to treat chronic conditions.

Various benefit and cost-sharing tradeoffs could be made to construct alternative packages with the same AV—for example, "mini-med" plans covering some outpatient care and no inpatient care (among other significant exclusions) or plans with very low annual maximum benefits. We did not model those types of packages because most people—and the Congressional Budget Office—likely would not consider them insurance.[10] Although a 25 percent AV plan is the most generous one that adults ages 61 to 64 could buy using only their tax credit, younger adults could purchase a higher AV plan with the credit amounts specified in the Empowering Patients First bill. *Because the proposed tax credit is a fixed amount for each age bracket and premiums can vary for each year of age within a bracket, coverage would become less affordable as a person aged through a particular bracket.*

People ages 18 to 20 in our risk pool could purchase a 70 percent AV plan with their Empowering Patients First tax credit, but no other age group could (table 1). The illustrative 70 percent AV plan has a $4,500 single/$9,000 family deductible, $6,850/$13,700 out-of-pocket maximums, and copayments at

the point of service. All the ACA's essential health benefits are included in this plan. People ages 35 to 39 in our risk pool could purchase a 60 percent AV plan with their tax credit, similar to the 70 percent AV option but with a $6,850/$13,700 single/family deductible. People ages 35 to 39, who are on the younger end of the 35-to-49 age bracket, could use their tax credit alone to purchase a more generous policy than younger adults who fall at the older end of the 18-to-34 age bracket.

TABLE 1

Examples of Health Insurance Plans That Nonelderly Adults Could Purchase Using Only the Refundable Tax Credit in the Empowering Patients First Bill

Actuarial value	Cost-sharing requirements	Benefits and exclusions	Age of adults able to buy policy with tax credit alone
70%	*Deductible (single/family)* $4,500/$9,000 plus copayments for services *Out-of-pocket maximum (single/family)* $6,850/$13,700	All EHB	18–20
60%	*Deductible (single/family)* $6,850/$13,700 *Out-of-pocket maximum (single/family)* $6,850/$13,700	All EHB	18–20 35–39
47%	*Deductible (single/family)* $6,850/$13,700 *Out-of-pocket maximum (single/family)* $6,850/$13,700	EHB excluding nongeneric Rx drugs, speech therapy, physical therapy, occupational therapy, outpatient mental health and outpatient substance use disorder treatment	18–28 35–46 50–52
41%	*Deductible (single/family)* $10,000/$20,000 *Out-of-pocket maximum (single/family)* $10,000/$20,000	EHB excluding nongeneric Rx drugs, speech therapy, physical therapy, occupational therapy, outpatient mental health and outpatient substance use disorder treatment	18–33 35–55
34%	*Deductible (single/family)* $15,000/$30,000 *Out-of-pocket maximum (single/family)* $25,000/$50,000	EHB excluding nongeneric Rx drugs, speech therapy, physical therapy, occupational therapy, outpatient mental health and outpatient substance use disorder treatment	18–60
25%	*Deductible (single/family)* $25,000/$50,000 *Out-of-pocket maximum (single/family)* $25,000/$50,000	EHB excluding nongeneric Rx drugs, speech therapy, physical therapy, occupational therapy, outpatient mental health and outpatient substance use disorder treatment	18–64

Source: Analysis based on the MEPS-HC consolidated data file, aged to 2016, and the Center for Consumer Information and Insurance Oversight's actuarial value calculator and minimum value calculator.
Notes: EHB = essential health benefits defined by the Affordable Care Act. Actuarial analysis based on national average second-lowest-cost silver Marketplace premium and plan specifics as starting point, adjusting for broader enrollee population and lower actuarial values.

In our risk pool, people ages 21 to 28, 40 to 46, and 50 to 52 could purchase a 47 percent AV plan using only their tax credit. One such plan would have the same cost-sharing structure as the 60 percent AV plan described above, but would exclude coverage for nongeneric prescription drugs, occupational therapy, speech therapy, physical therapy, rehabilitative care, and outpatient mental health and substance use disorder treatment. People ages 29 to 33, 47 to 49, and 53 to 55 could purchase a 41 percent AV plan using only their tax credit. Our illustrative plan includes a $10,000 single/$20,000 family deductible, out-of-pocket maximums at the same levels, and all of the aforementioned benefit exclusions.

All people ages 60 and younger in the risk pool could purchase a 34 percent AV plan using only their tax credit. An illustrative plan at this level would have a $15,000 single/$30,000 family deductible, $25,000/$50,000 out-of-pocket maximums, and all of the above benefit exclusions. People ages 61 to 64 could purchase a 25 percent or lower AV plan using only the tax credit; this plan would have the $25,000/$50,000 deductibles and out-of-pocket maximums and benefit exclusions already described.

The Empowering Patients First bill stipulates that tax credit amounts would increase each year with general inflation. Historically, general inflation increases more slowly than health care costs (Hughes-Cromwick et al. 2017). Thus, the amount of medical care covered by the tax credit would fall each year. For an individual or family to buy a policy using only the credit, additional benefits would have to be excluded and/or cost-sharing would have to increase over time.

Do People Typically Have Sufficient Assets to Cover Such High Deductibles?

A study using 2013 data estimated median liquid and net financial assets for nonelderly, nonpoor households (Claxton, Rae, and Panchal 2015). Liquid financial assets include checking and savings accounts, money market accounts, certificates of deposit, savings bonds, nonretirement mutual funds, and stocks and bonds, but exclude the value of dedicated retirement accounts and the cash value of life insurance. Net financial assets include all financial assets (including dedicated retirement accounts) minus unsecured debts (credit card debt and other unsecured loans). The study found that the median single adult household had liquid financial assets of $2,503 and net financial assets of $1,369. The median multiperson household had liquid financial assets of $5,527 and net financial assets of $3,267. Both measures of median assets varied significantly with income. People with incomes between 100 and 250 percent of FPL had median liquid assets of $766 and median net financial assets of $326. People with incomes above 400 percent of FPL had median liquid assets of $18,343 and median net assets of $16,394.

Based on these asset estimates, the vast majority of nonelderly people could not afford the out-of-pocket requirements for the plans described here if they experienced a serious illness or injury. In addition, those with serious conditions could see their medical needs accrue over more than one plan year, making their potential out-of-pocket liability two or more times the amounts computed here.

Discussion

With financial assistance limited to people with low or modest incomes, a given level of aggregate federal spending can provide higher levels of aid to each eligible person or family. Spreading those aggregate federal dollars across people of all incomes will necessarily dilute the assistance provided per person or family eligible for assistance, unless much larger commitments of federal dollars are made in total. This approach would provide new financial assistance to higher-income people, but would make it impossible for most lower-income people to purchase adequate health insurance coverage, given their limited financial resources and potential medical needs.

The Empowering Patients First bill's nongroup insurance tax credit would not only spread the assistance funds across people of all income levels, but it would also increase the premiums older adults would pay relative to younger adults, without a commensurate increase in federal assistance. We assumed, conservatively, that insurers would sell equivalent coverage to a 64-year-old for five times the premium charged an 18-year-old. Yet the Empowering Patients First tax credit for an 18-year-old would be $1,200 per year, compared with $3,000 for a 64-year-old. Thus, the 64-year-old's tax credit would be 2.5 times that for the youngest adults, but the older person's premium could be at least 5 times that for the youngest adults for the same insurance plan. Under this policy, the older a person became and the more likely they were to need significant medical care, the less affordable their insurance would be. A 25 percent AV plan would be the most generous option available to those ages 61 to 64 paying only with the tax credit, and a 34 percent AV plan would be the most generous available to those ages 56 to 60. For any adult age 18 to 64 to purchase our illustrative ACA-compliant 70 percent plan using only their tax credit under 5:1 age rating, the tax credit provided to a 64-year-old would have had to be approximately $8,200 in 2016 (data not shown) instead of $3,000, and that assumes no cost-sharing assistance for lower-income people.

In states that permit insurers to age-rate premiums by a ratio greater than 5:1, this effect would be even more severe, and more adults would face financial difficulty as they aged. Providing tax credits of fixed amounts for specific age brackets (in the Empowering Patients First bill, ages 18 to 34, 35 to 49, and 50 and older), while allowing premiums to vary for each year of age within a bracket, makes coverage less affordable as a person ages through a particular bracket. To the extent that insurers could also vary premiums by other factors (e.g., gender; occupation; duration of coverage; and, for those not maintaining continuous coverage, health status), more people would have to purchase even narrower coverage in order to pay for it only with their tax credit. Likewise, those living in higher-than-average medical cost areas would be able to purchase less generous coverage with their credit than those living in lower cost areas. Restricting growth in the amount of the tax credit to general inflation would significantly erode the value of the credit over time.

It is unclear whether insurers would be able to sell policies with $25,000 single/$50,000 family deductibles—more than five times the average silver plan deductibles today—or even policies with $10,000 single/$20,000 family deductibles. Given the limited assets held by even nonpoor, nonelderly individuals and families, the vast majority of people are unlikely to gain much if any value from such

policies. Thus, people may prefer to deposit these tax credits into health savings accounts (HSAs) instead of using them to purchase very low-value insurance policies. The Empowering Patients First bill would allow people to deposit unused tax credits into HSAs, and at least one ACA alternative proposal would eliminate the requirement that HSAs be associated with an insurance policy.[11]

Though HSAs have clear tax benefits for high-income people, a shift away from insurance and toward independent HSAs (or HSAs coupled with even higher deductibles than currently permitted) would substantially decrease the sharing of health care risk. Individuals with significant medical needs would quickly use up their HSA allotments and be left to finance the rest of their health care (or larger percentages of it) out of their own pockets. Because most people would not have enough money to fund necessary medical care in such circumstances, broad and long-term sharing of health care risk remains a more attractive policy option.

TECHNICAL APPENDIX

We relied exclusively on publicly available data to conduct this analysis. Marketplace premiums and Marketplace population demographics were obtained from enrollment reports produced by the Office of the Assistant Secretary for Planning and Evaluation (ASPE 2016a, 2016b). Using the Robert Wood Johnson Foundation's HIX Compare data, we identified a single silver plan option with a premium roughly equal to the national average second-lowest-cost silver premium. This Michigan Marketplace silver plan has a $4,500 single medical deductible, $1,000 drug deductible, $6,850 out-of-pocket maximum with physician copayments of $10 for primary care and $30 for specialty care, and drug copays in four tiers ($5/$40/$120/$250).

This silver plan was used as a starting point for constructing an illustrative plan for which premiums did not exceed the tax credit amounts specified in the Empowering Patients First bill: $900 per child up to age 18; $1,200 for people ages 18 to 34; $2,100 for people ages 35 to 49; $3,000 for people ages 50 and older. We used the actuarial value calculator (AVC) and the minimum value calculator (MVC) from the Center for Consumer Information and Insurance Oversight to verify the AV of the starting silver plan and to determine AVs for less comprehensive plans, searching for one plan that would allow any person age 18 to 64 to use the tax credit to pay the premium in full. The AVC provides quantitative estimates of the AV for a particular plan design, assuming a standard population and essential health benefit requirements. The MVC is a similar tool used to calculate the value of employer-based plans and "grandfathered" plans, and therefore can be used for plans with AV below 60 percent.

The starting silver plan was used to model an average level of spending for those in the current Marketplace pool. We expanded our risk pool for this exercise to include all current nongroup insurance enrollees (those covered through Marketplace or non-Marketplace coverage under the ACA) as well as a random one-third of those uninsured under current law. We used data from the 2014 Household Component of the Medical Expenditure Panel Survey to estimate relative costs by type of insurance coverage and counts by age.[a] These data allowed us to adjust the starting point premium for the silver plan based on the relative age and expense levels of the added population groups.

We analyzed alternative plans by adjusting parameters in the second-lowest-cost silver starting plan. We rated the plans using the AVC and MVC, starting with silver on the AVC and MVC, and then moved to the MVC when AVs dropped below silver, using the calculator's "grandfathered" option. The costs of these alternative plans were first calculated by using the ratio of the plan's calculated AV to the second-lowest-cost silver value, adjusting for changes in health care use that occur as benefits and cost-

sharing become more or less generous (behavioral adjustment); then, we added an appropriate administrative load based on assumed medical loss ratios. For example, if we assume a $2,900 starting premium for a silver plan for a 24-year-old, then the premium when moving to a bronze plan with slightly higher administrative costs and induction is calculated as follows:

$$Lower\ AV\ Premium = Higher\ AV\ Premium * (ratio\ of\ AVs) * (ratio\ of\ administrative\ costs) * (behavioral\ adjustment), or$$

$$\$2545 = \$2900 * \left(\frac{0.6}{0.7}\right) * \left(\frac{1.333}{1.25}\right) * .96$$

The administrative cost factor 1.333 reflects a plan with a medical loss ratio (MLR) of 75 percent, and 1.25 reflects an MLR of 80 percent (1.333=1/0.75; 1.25=1/0.80); these MLR differences are discussed below. The premium differentials widen as plan AVs decrease because both the ratio of the AVs and the ratio of the behavioral factors fall.

To calculate the behavioral adjustment, we used standard actuarial adjustments for the effects of higher cost-sharing requirements on individuals' and families' use of medical care.[b]

Premiums for each year of age were calculated using 5:1 age indices and adjusted to reproduce the average premiums as calculated post–behavioral adjustment. Members of Congress proposing alternatives to the ACA frequently suggest loosening the law's 3:1 age rating limits, allowing each state to decide how much variation to permit, with a suggested 5:1 minimum. Though such approaches would permit variation broader than 5:1, we assume a 5:1 age rating curve because it is the most frequently cited approach. We do not estimate the effects of additional rating factors that insurers could use, such as gender and occupation, and we do not estimate the effects of a provision in the Empowering Patients First plan that would allow insurers to charge higher premiums based on health status if the applicant had not maintained continuous coverage. In addition, we do not account for the fact that people living in higher medical cost areas would face higher premiums than those living in lower medical cost areas; our estimates reflect national averages. *All of these conditions—wider age rating bands, additional rating factors, and geographic cost differences—would make more people unable to purchase the specified levels of coverage using only the proposed tax credit. Without accounting for these conditions, our estimates represent upper bounds on the generosity of coverage that could be purchased using only the proposed tax credits.*

Insurers could lower costs by using very restrictive provider networks and very low provider payment rates, arguing that these plans have a higher AV than the option presented here. We do not account for that scenario, largely because such limits would have to be substantially tighter than the ones in limited network plans already provided through many state Marketplaces, and because such plans would likely be unattractive to most consumers. In addition, significantly narrower network plans could severely limit access to care.

The ACA requires that nongroup market insurers' MLRs (the share of premiums attributable to claims paid and quality assurance expenses as opposed to administrative expenses) be no lower than 80 percent. If an insurer's MLR falls below 80 percent, the company must refund the difference to its enrollees. We assume that the MLR requirements would be repealed as part of an ACA replacement, consistent with the Empowering Patients First bill. Because nongroup market MLRs generally fell below 80 percent before 2014 (Clemans-Cope et al. 2013) and because the share of premiums attributable to administrative costs increases with lower AV plans, we assume MLRs of 75 percent for plans with AVs between 45 and 60 percent and MLRs of 70 percent for plans with AVs below 45 percent. Lower MLRs mean that the policies that can be purchased at a given premium are of lower value to the consumer; a larger percentage of the premium is attributable to administrative costs and a lower percentage to claims paid.

We continued to compute plans with lower AV until we identified a plan that all people ages 18 to 64 in the risk pool could purchase using only their age-related tax credit. For each of the computed

plans, we recalculated covered health care spending levels and premiums for each year of age and appropriate utilization effects (i.e., lower use of care as cost-sharing requirements increased). We then compared premiums for each year of age to the proposed tax credit for a person of that age to see which adults could buy that plan using only the credit. If adults of any age were unable to purchase the constructed plan with the tax credit proposed, we reduced the AV of the plan further, recomputed covered expenses and premiums, and checked again. For each plan level, we assumed the adults ages 18 to 64 were in a single risk pool.

[a] The MEPS-HC's nationally representative data for this insurance pool include 34,875 observations.

[b] For example, higher deductibles lead to lower use of care. The estimated change in covered charges was set equal to (-α)* change in out-of-pocket costs, where α=0.2 for hospital care, 0.7 for physician care, and 1.0 for prescription drugs.

Notes

1. Empowering Patients First Act of 2015, H.R. 2300, 114th Cong. (2015); and "A Better Way: Health Care," Office of the Speaker of the House, June 22, 2016, http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf.
2. "Internal Revenue Bulletin: 2016-18," Internal Revenue Service, published May 2, 2016, https://www.irs.gov/irb/2016-18_IRB/ar08.html.
3. Russell Berman, "The Republican Health Plan That Doesn't Repeal Obamacare," *The Atlantic*, January 24, 2017, https://www.theatlantic.com/politics/archive/2017/01/the-republican-health-plan-that-doesnt-repeal-obamacare/514175/; and "GOP Reportedly Considers Plan to Automatically Sign Americans Up for Insurance," Advisory Board Daily Briefing, January 20, 2017, https://www.advisory.com/daily-briefing/2017/01/20/auto-enroll.
4. Proposed alternatives have not required risk adjustment across nongroup insurers or other risk-sharing strategies. However, even if risk adjustment were required, it would be very difficult to design and implement where plan actuarial values and benefits vary substantially.
5. Some states do have nominal cost-sharing requirements for some Medicaid enrollees.
6. "March 31, 2016 Effectuated Enrollment Snapshot," Centers for Medicare and Medicaid Services, published March 31, 2016, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html.
7. A few states have tighter age bands under the ACA: New York and Vermont require pure community rating (no premium variation by age), and Massachusetts uses 2:1 rating.
8. The MEPS-HC's nationally representative data for this insurance pool include 34,875 observations.
9. In addition, the Empowering Patients First plan specifies that some people who fail to maintain continuous coverage would be subject to health status rating. We do not account for that in this analysis.
10. Jared Maeda and Susan Yeh Beyer, "How Does CBO Define and Estimate Health Insurance Coverage for People Under Age 65?," CBO Blog, December 20, 2016, https://www.cbo.gov/publication/52352.
11. Obamacare Replacement Act, S. 222, 115th Cong. (2017).

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Linda J. Blumberg is a senior fellow in the Health Policy Center at the Urban Institute, having joined in 1992. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA); in particular, providing technical assistance to states, tracking policy decisionmaking and implementation efforts at the state level, and interpreting and analyzing the implications of particular policies. She codirects a large multiyear project using qualitative and quantitative methods to monitor and evaluate ACA implementation in states and nationally. Examples of her research include several analyses of competition in nongroup Marketplaces, estimation of the implications of ACA repeal through the reconciliation process, strategies for improving the ACA, an array of studies on the implications of the *King v. Burwell* Supreme Court case, analysis of the remaining uninsured, and codirecting 22 state case studies of stakeholder perspectives on ACA implementation. She also led the quantitative analysis supporting the development of a "Roadmap to Universal Coverage" in Massachusetts, a project with her Urban colleagues that informed the 2006 comprehensive reforms in that state. She received her PhD in economics from the University of Michigan.

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