

U.S. Health Reform—Monitoring and Impact

Premium Tax Credits Tied to Age Versus Income and Available Premiums: Differences by Age, Income, and Geography

May 2017

By John Holahan, Linda J. Blumberg, and Erik Wengle



Robert Wood Johnson
Foundation

Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.



With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at www.rwjf.org and www.healthpolicycenter.org.

INTRODUCTION

On May 4, 2017, House Republicans passed the American Health Care Act (AHCA) as a replacement for the Affordable Care Act (ACA). The bill would replace the income- and premium-related tax credits in the ACA with age-varying tax credits. The bill now moves to the Senate, where it is expected to be revised before formal consideration. While the bill's fate in the Senate is currently unclear, even a significantly revised version may include age-related tax credits because they are administratively simple and lack any possible work-disincentive effects of tax credits that phase out as income increases (although the AHCA's tax credits do phase out at relatively high incomes).

In this brief, we argue that age-related tax credits, as opposed to the ACA's tax credits that vary by income and the actual premiums faced, provide insufficient help to people with low incomes, people in high premium markets, and people as they near age 65.

Because age-related tax credits maintain political currency and are likely to be part of the Senate's adaptation of or alternative to the AHCA, we compare the value of tax credits under the ACA and the AHCA for individuals at three ages, four income groups, and 10 urban insurance markets. The ACA tax credits cover the difference between the second-lowest-cost premium for a silver plan and a percentage of income. Thus, people who are eligible for tax credits are protected against high-premium plans, whether premiums are high because

the person is older or because the person lives in a high-cost geographic area. The AHCA tax credits increase not with income but with age (\$2,000 for people younger than age 30 and \$4,000 for people ages 60 and older); at higher incomes, the tax credits are phased out. The differences between the two types of tax credits are illustrated in Table 1.

We examine premiums for people at ages 25, 45, and 64, and the impact of tax credits on an example family. We present findings for the following income levels: 150 percent, 250 percent, 350 percent, and 450 percent of the federal poverty level (FPL), levels equivalent to \$17,820; \$29,700; \$41,580; and \$53,460 for a single adult, respectively in 2017. We include the following cities: Cleveland, OH; Detroit, MI; Seattle, WA; Providence, RI; Los Angeles, CA; Birmingham, AL; Oklahoma City, OK; Tucson, AZ; Charleston, WV; and Charlotte, NC. The first five markets have relatively low premiums because they have a large number of competing insurers and/or because they have Medicaid insurers (managed-care insurers that only provided coverage for Medicaid beneficiaries before the ACA was implemented), provider-sponsored insurers, or Blue Cross HMO insurers operating in their markets. The last five markets have relatively high premiums, largely because they have considerably less competition (e.g., only one or two insurers).

Two recent analyses modeled the effects of the proposed tax credits. The Kaiser Family Foundation created a tool comparing tax credits under the ACA with those in the proposed AHCA

Table 1: Comparison of ACA and AHCA Tax Credits

ACA		AHCA	
Income as percent of federal poverty level	Maximum percentage of income enrollee pays towards premium	Age	Tax credit
100-133%	2.04%	Under 30	\$2,000
133-150%	3.06-4.08%	30-39	\$2,500
150-200%	4.08-6.43%	40-49	\$3,000
200-250%	6.43-8.21%	50-59	\$3,500
250-300%	8.21-9.69%	60+	\$4,000
300-400%	9.69%		
Over 400%	No cap		

Note: The ACA's tax credits are linked to benchmark premiums each year, and we have ACA premium data for 2017 but not for future years. The AHCA delineates its new tax credits beginning in 2020. As a consequence, we compare 2017 ACA tax credits with the 2020 AHCA tax credits. This comparison has the effect of making the AHCA tax credits look larger relative to ACA tax credits than would actually be the case. An apples to apples comparison would require deflating the AHCA tax credit amounts by CPI + 1 percentage point for each year between 2017 and 2020.

at three different ages and various incomes.¹ Kaiser's results are similar to ours in that they show how the AHCA would redistribute tax credits along the income scale, with lower-income people receiving less financial assistance under the AHCA than under the ACA. *The New York Times* Upshot used Kaiser's data to illustrate the effects of a shift from the ACA to the AHCA for different geographic areas, but its analysis focused on the expected impacts for people who voted for Donald

Trump in the 2016 presidential election.² The *Times* found that Trump supporters were the group most likely to receive less assistance under the AHCA, given their age and location. We focus on 10 cities to show that marketplace competition and associated premiums in large part determine whether people would be better off under the ACA or the AHCA. There is nothing in the AHCA that would increase insurance market competition.

DATA AND METHODS

We present premium tax credit data for three different ages (25, 45, and 64) and four income levels (150, 250, 350, and 450 percent of FPL) in 10 different cities (five low-cost and five high-cost). We present a similar analysis for an example family. We use the benchmark plan premium in each city and the corresponding ACA percent-of-income cap to calculate the value of the ACA advanced premium tax credit for a person of that age and income living in that city. The data were drawn from Healthcare.gov public use files and relevant state-based marketplace websites. We compare the value of the refundable age-related tax credit in the AHCA with the ACA credit; the former does not vary by geographic location or income (at the incomes studied here), but it does vary by age. We present the deductible and out-of-pocket maximum for each city's benchmark silver plan as well as deductibles and out-of-

pocket maximums under the three cost-sharing reduction plans (94 percent, 87 percent, and 73 percent actuarial value) associated with the benchmark. We show these to highlight the value of the ACA's cost-sharing reductions to consumers. The AHCA does not offer financial assistance to lower the cost of deductibles, co-payments, co-insurance, or out-of-pocket maximums, so Table 4 only includes cost-sharing information for the ACA. The ACA's tax credits are linked to benchmark premiums each year, and we have ACA premium data for 2017 but not for future years. The AHCA delineates its new tax credits beginning in 2020. As a consequence, we compare 2017 ACA tax credits with the 2020 AHCA tax credits. This comparison has the effect of making the AHCA tax credits look larger relative to ACA tax credits than would actually be the case. An apples to apples comparison would require deflating the AHCA tax credit

amounts by CPI + 1 percentage point for each year between 2017 and 2020.

This analysis is a simple comparison of the sizes of tax credits that different people would receive. It does not take into account differences in the types of insurance that may be available under each policy (e.g., benefits, actuarial values), differences in unsubsidized premiums for people of different

ages, potential differences in access to care for people of various health statuses, or any other rating factors that may be permitted in some states (e.g., health status). Thus, we cannot conclude that a person receiving a larger tax credit at a particular age or income under a particular option is better off than they would be under the alternative.

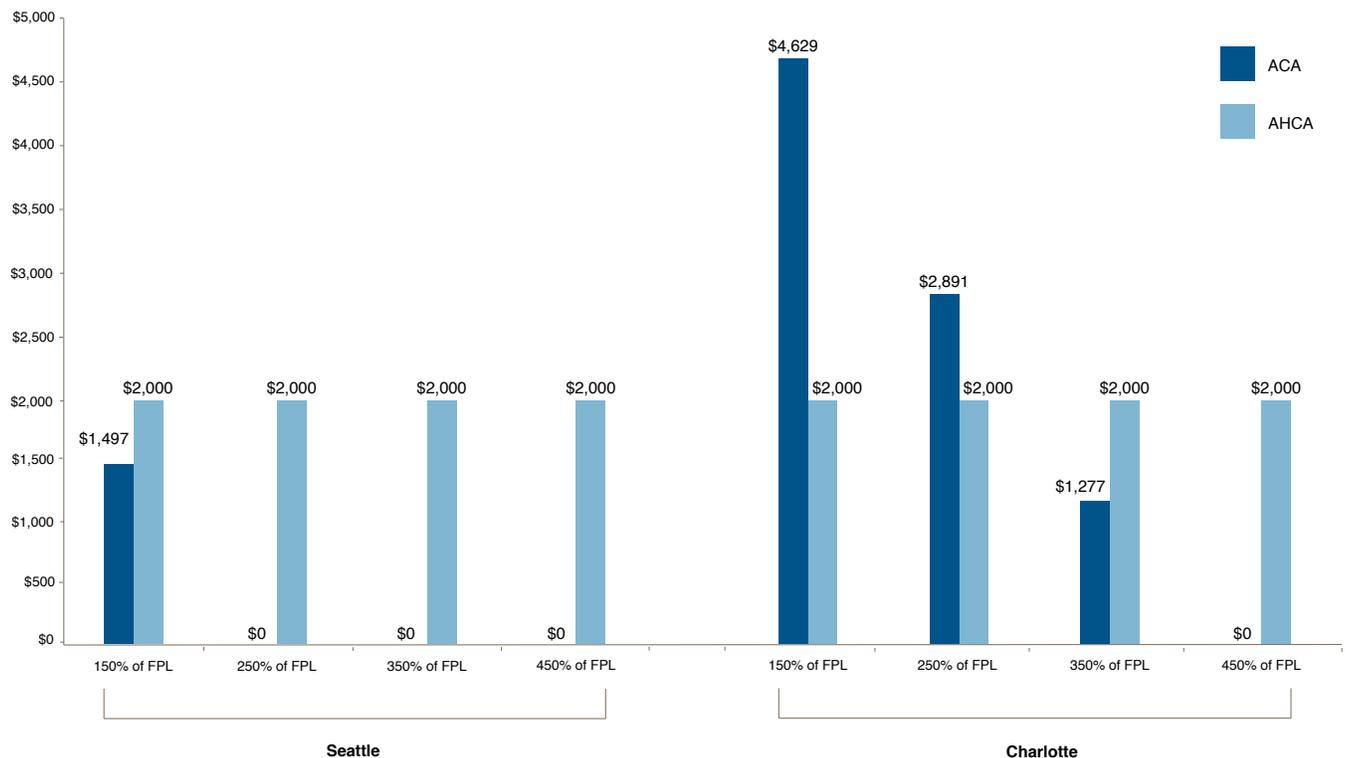
RESULTS

Premium Tax Credits: ACA versus AHCA

Our results show that younger people typically would receive larger premium tax credits under the AHCA, and older adults (64-year-olds in our analysis) typically would receive larger premium tax credits under the ACA. Lower-income people tend to be eligible for larger tax credits under the ACA, and higher-income people tend to receive larger tax credits under the AHCA. People in more competitive markets with low premiums generally receive larger tax credits under the AHCA, and people

in less competitive markets with high premiums generally receive larger tax credits under the ACA. However, each case has a number of exceptions. We organize our results by age and show how tax credits under the two plans differ for people at three ages, four income levels, and ten geographic areas. The numbers in the tables are shaded to illustrate which premium tax credit approach, ACA or AHCA, offers larger premium tax credits to each person. The higher premium tax credit is shaded blue.

Figure 1. Premium Tax Credit for a 25-Year-Old, ACA v. AHCA, in Seattle and Charlotte



Age 25

Table 2 and Figure 1 show that whether a 25-year-old would receive a higher tax credit under the ACA or under the AHCA differs significantly based on his or her income and whether he or she lives in a high-premium or low-premium area. Twenty-five year olds at both 150 and 250 percent of FPL receive higher tax credits under the ACA if they live in high-premium areas (Birmingham, Oklahoma City, Tucson, Charleston, and Charlotte), but receive higher tax credits under the AHCA if they live in low-premium areas (Cleveland, Detroit, Seattle, Providence, Los Angeles). Young adults with incomes of 350 and 450 percent of FPL would receive large premium tax credits under the AHCA, regardless of the city they live in, because the AHCA's tax credits do not decrease for people in this higher income range.

For example, a 25-year-old with an income of 250 percent of FPL living in a low-cost market would be eligible under the ACA for a very small tax credit or none at all because the premium he or she faces would fall below the percentage-of-income cap that applies to him or her. In Los Angeles, the ACA tax credit would be only \$7 per year, and in Seattle it would be \$0; compare this to the AHCA tax credit of \$2,000 in each market. In the high-premium markets, on the other hand, the ACA tax credits are greater than the AHCA tax credits for people at that same income level of 250 percent of FPL. For example, that same 25-year-old would receive \$2,891 in ACA tax credits in Charlotte versus \$2,000 in all markets under the AHCA. At income of 350 percent of FPL, the ACA tax credit in low-premium markets is \$0 as well because the benchmark premiums are less than the percentage-of-income cap of 9.69 percent; people at that income level would receive \$2,000 in credits under the AHCA. At 350 percent of FPL, the ACA tax credits are less than the AHCA credits even in high-cost markets since the former decrease with increasing income. At 450 percent of FPL, the ACA provides no financial assistance, while the AHCA would continue to provide \$2,000 in each market.

Age 45

Similar findings hold for 45-year-olds (Table 2). For people with incomes of 150 percent of FPL, the AHCA tax credits are greater than the ACA tax credits in the low-premium, more competitive insurance markets, but the ACA tax credits are far greater in the high-premium markets: ACA tax credits are \$5,937 in Birmingham and \$7,012 in Charlotte compared with \$3,000 AHCA tax credits in all. The same is true for those at 250 percent of FPL: people living in the low-premium markets would receive

larger tax credits under the AHCA than they do under the ACA (in Seattle, for example, the AHCA credits are \$3,000 versus \$753, respectively), while those in the high-premium markets receive larger ACA tax credits (in Charlotte, for example, \$5,274 under the ACA versus \$3,000 under the AHCA). For those at 350 percent of FPL, AHCA tax credits are greater in all but the two most expensive markets. At 450 percent of FPL, the AHCA would provide tax credits, but the ACA does not.

Age 64

The results (Table 2 and Figure 2) show that 64-year-olds generally receive higher tax credits under the ACA than they would under the AHCA; AHCA tax credits would have to be increased significantly for this to change. For 64-year-olds with incomes of 150 percent of FPL, the ACA provides substantially higher tax credits in all markets. The same is true for those with incomes of 250 percent of FPL in all but the least costly market studied (Cleveland). Premiums increase with age, and therefore the ACA's structure, which ties financial assistance to the size of the premium faced, provides protection to older adults that the AHCA does not. The AHCA tax credits vary by a factor of two to one from oldest to youngest adult, while premiums under it could vary by five to one (states could choose to have them vary by more or less than five to one, but the bill considers five to one standard). The ACA's premiums vary by a more limited factor, no more than three to one for oldest to youngest adults, but its premium tax credits keep up with that premium variation as people age. In a low-price market such as Seattle, the ACA tax credit for a 64-year-old with income of 150 percent of FPL is \$5,968; under the AHCA, that tax credit would be \$4,000. In a high-price market such as Charlotte, the ACA subsidy is \$15,362, while the AHCA tax credit would be \$4,000. For 64-year-olds with incomes of 250 percent of FPL, the ACA tax credits are modestly larger than the AHCA credits in low-premium markets (with the exception of Cleveland), but in the high-premium markets, the ACA credits are substantially greater (e.g. \$ 12,568 in Charleston and \$13,625 in Charlotte versus \$4,000 in both markets under the AHCA).

For 64-year-olds with incomes of 350 percent of FPL, the ACA tax credits are significantly lower than for those with lower incomes because the percentage of income that these higher-income individuals are expected to pay toward their coverage is higher. Importantly, however, ACA tax credits are still tied to the actual premiums faced by people at this income level, so their tax credits can still be quite large in high premium cities. For 64-year-olds, the AHCA tax subsidies are greater than the

Table 2. Comparison of ACA and AHCA Tax Credits by Age and Income for Selected Cities

25-year-old	150% of FPL		250% of FPL		350% of FPL		450% of FPL	
	ACA	AHCA	ACA	AHCA	ACA	AHCA	ACA	AHCA
Cleveland	\$1,412	\$2,000	\$0	\$2,000	\$0	\$2,000	\$0	\$2,000
Detroit	\$1,483	\$2,000	\$0	\$2,000	\$0	\$2,000	\$0	\$2,000
Seattle	\$1,497	\$2,000	\$0	\$2,000	\$0	\$2,000	\$0	\$2,000
Providence	\$1,710	\$2,000	\$0	\$2,000	\$0	\$2,000	\$0	\$2,000
Los Angeles	\$1,744	\$2,000	\$7	\$2,000	\$0	\$2,000	\$0	\$2,000
Birmingham	\$3,885	\$2,000	\$2,148	\$2,000	\$533	\$2,000	\$0	\$2,000
Oklahoma City	\$3,894	\$2,000	\$2,156	\$2,000	\$542	\$2,000	\$0	\$2,000
Tucson	\$3,977	\$2,000	\$2,240	\$2,000	\$625	\$2,000	\$0	\$2,000
Charleston, WV	\$4,276	\$2,000	\$2,539	\$2,000	\$924	\$2,000	\$0	\$2,000
Charlotte	\$4,629	\$2,000	\$2,891	\$2,000	\$1,277	\$2,000	\$0	\$2,000
45-year-old	150% of FPL		250% of FPL		350% of FPL		450% of FPL	
	ACA	AHCA	ACA	AHCA	ACA	AHCA	ACA	AHCA
Cleveland	\$2,366	\$3,000	\$629	\$3,000	\$0	\$3,000	\$0	\$3,000
Detroit	\$2,470	\$3,000	\$733	\$3,000	\$0	\$3,000	\$0	\$3,000
Seattle	\$2,490	\$3,000	\$753	\$3,000	\$0	\$3,000	\$0	\$3,000
Providence	\$2,797	\$3,000	\$1,060	\$3,000	\$0	\$3,000	\$0	\$3,000
Los Angeles	\$2,847	\$3,000	\$1,109	\$3,000	\$0	\$3,000	\$0	\$3,000
Birmingham	\$5,937	\$3,000	\$4,200	\$3,000	\$2,585	\$3,000	\$0	\$3,000
Oklahoma City	\$5,950	\$3,000	\$4,213	\$3,000	\$2,598	\$3,000	\$0	\$3,000
Tucson	\$6,071	\$3,000	\$4,334	\$3,000	\$2,719	\$3,000	\$0	\$3,000
Charleston, WV	\$6,503	\$3,000	\$4,766	\$3,000	\$3,151	\$3,000	\$0	\$3,000
Charlotte	\$7,012	\$3,000	\$5,274	\$3,000	\$3,660	\$3,000	\$0	\$3,000
64-year-old	150% of FPL		250% of FPL		350% of FPL		450% of FPL	
	ACA	AHCA	ACA	AHCA	ACA	AHCA	ACA	AHCA
Cleveland	\$5,711	\$4,000	\$3,973	\$4,000	\$2,359	\$4,000	\$0	\$4,000
Detroit	\$5,926	\$4,000	\$4,189	\$4,000	\$2,574	\$4,000	\$0	\$4,000
Seattle	\$5,968	\$4,000	\$4,231	\$4,000	\$2,616	\$4,000	\$0	\$4,000
Providence	\$6,606	\$4,000	\$4,869	\$4,000	\$3,254	\$4,000	\$0	\$4,000
Los Angeles	\$6,709	\$4,000	\$4,972	\$4,000	\$3,357	\$4,000	\$0	\$4,000
Birmingham	\$13,131	\$4,000	\$11,393	\$4,000	\$9,778	\$4,000	\$0	\$4,000
Oklahoma City	\$13,157	\$4,000	\$11,420	\$4,000	\$9,805	\$4,000	\$0	\$4,000
Tucson	\$13,408	\$4,000	\$11,670	\$4,000	\$10,056	\$4,000	\$0	\$4,000
Charleston, WV	\$14,306	\$4,000	\$12,568	\$4,000	\$10,954	\$4,000	\$0	\$4,000
Charlotte	\$15,362	\$4,000	\$13,625	\$4,000	\$12,010	\$4,000	\$0	\$4,000

Note: The ACA's tax credits are linked to benchmark premiums each year, and we have ACA premium data for 2017 but not for future years. The AHCA delineates its new tax credits beginning in 2020. As a consequence, we compare 2017 ACA tax credits with the 2020 AHCA tax credits. This comparison has the effect of making the AHCA tax credits look larger relative to ACA tax credits than would actually be the case. An apples to apples comparison would require deflating the AHCA tax credit amounts by CPI + 1 percentage point for each year between 2017 and 2020.

Figure 2. Premium Tax Credit for a 64-Year-Old, ACA v. AHCA, in Seattle and Charlotte

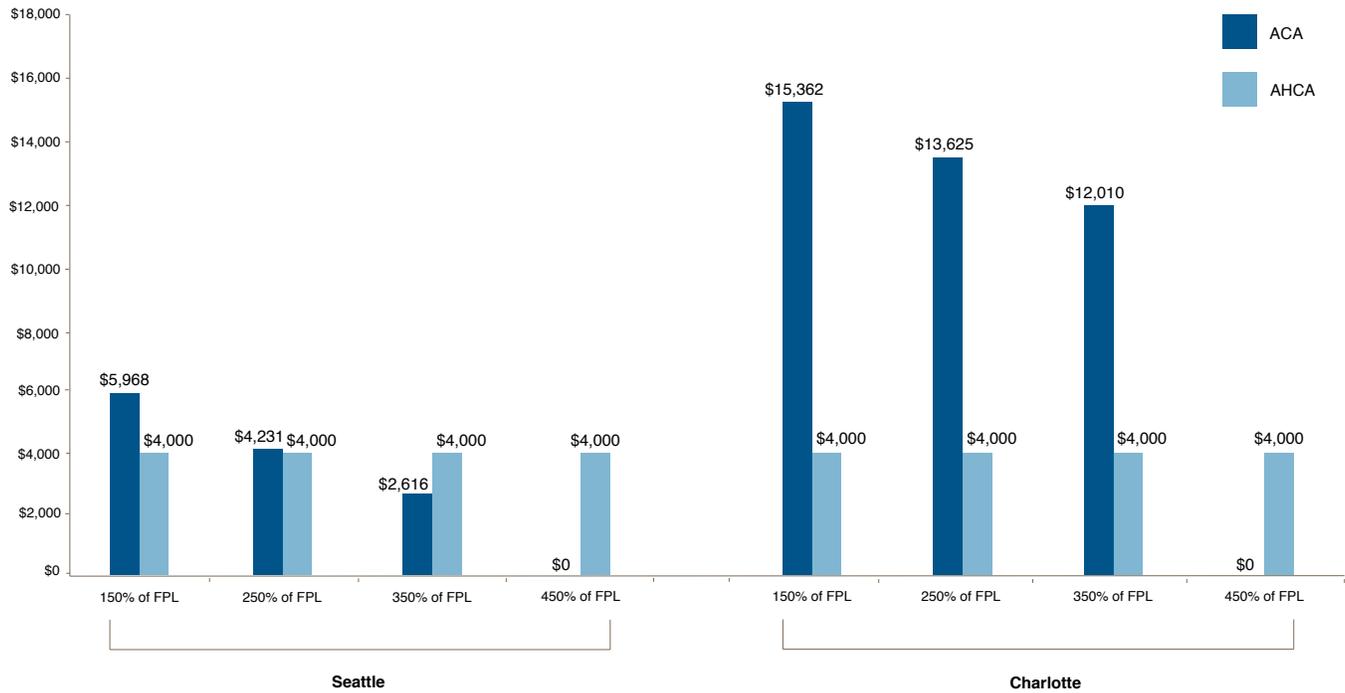


Table 3. Comparison of Premium Tax Credits for a Family of Four under the ACA and the AHCA (Two 35-year-old adults and two children), for Selected Cities

	150% of FPL		250% of FPL		350% of FPL		450% of FPL	
	ACA	AHCA	ACA	AHCA	ACA	AHCA	ACA	AHCA
Cleveland	\$6,478	\$9,000	\$2,934	\$9,000	\$0	\$9,000	\$0	\$9,000
Detroit	\$6,745	\$9,000	\$3,201	\$9,000	\$0	\$9,000	\$0	\$9,000
Seattle	\$6,797	\$9,000	\$3,253	\$9,000	\$0	\$9,000	\$0	\$9,000
Providence	\$7,586	\$9,000	\$4,043	\$9,000	\$0	\$9,000	\$0	\$9,000
Los Angeles	\$7,714	\$9,000	\$4,171	\$9,000	\$877	\$9,000	\$0	\$9,000
Birmingham	\$15,664	\$9,000	\$12,120	\$9,000	\$8,826	\$9,000	\$0	\$9,000
Oklahoma City	\$15,697	\$9,000	\$12,153	\$9,000	\$8,859	\$9,000	\$0	\$9,000
Tucson	\$16,007	\$9,000	\$12,463	\$9,000	\$9,169	\$9,000	\$0	\$9,000
Charleston, WV	\$17,119	\$9,000	\$13,575	\$9,000	\$10,281	\$9,000	\$0	\$9,000
Charlotte	\$18,427	\$9,000	\$14,883	\$9,000	\$11,589	\$9,000	\$0	\$9,000

Note: The ACA's tax credits are linked to benchmark premiums each year, and we have ACA premium data for 2017 but not for future years. The AHCA delineates its new tax credits beginning in 2020. As a consequence, we compare 2017 ACA tax credits with the 2020 AHCA tax credits. This comparison has the effect of making the AHCA tax credits look larger relative to ACA tax credits than would actually be the case. An apples to apples comparison would require deflating the AHCA tax credit amounts by CPI + 1 percentage point for each year between 2017 and 2020.

ACA tax credits in the low-premium markets, but in the high-premium markets, they would still receive much greater tax credits under the ACA than under the AHCA. In Charlotte, for example, the ACA tax credit at 350 percent of the FPL would be \$12,010, while the AHCA tax credit would be \$4,000. Again, the ACA does not provide tax credits to 64-year-olds with incomes over 400 percent of FPL, so people at 450 percent of FPL would receive a tax credit under the AHCA (\$4,000) but not under the ACA.

Families

In Table 3 we look at family premiums, using a family of four as an illustrative example (two 35-year-old adults and two children). At an income of 150 percent of FPL (\$36,450 in 2017), AHCA tax credits are greater for families in low-premium markets. In high-premium markets, the ACA tax credits are greater for families at that same income level. In Charleston, WV, for example, the ACA tax credit for a family with income of 150 percent of FPL would be \$17,119. A comparable family would receive \$9,000 in tax credits under the AHCA. This same pattern holds for incomes of 250 percent of FPL (\$60,750 in 2017): in the low-premium markets, the AHCA tax credits are higher, and the reverse is true in the high-premium markets, where the ACA tax credits are considerably greater than the AHCA ones. For families with incomes of 350 percent of FPL (\$85,050 in 2017), again the same pattern holds. Families who would receive no tax credits under the ACA (such as those in Cleveland, Detroit, Seattle, and Providence) would receive \$9,000 in AHCA tax credits. But in some high-price markets (such as Charleston and Charlotte), the ACA tax credits are substantially greater. In other markets, however, families with incomes of 350 percent of FPL or over 450 percent of FPL would receive higher tax credits under the AHCA.

Cost-Sharing Reductions: ACA Only

Under the ACA, each marketplace-participating insurer must offer at least one silver-level plan, and each silver-level plan must have cost-sharing reduction plans associated with it that accommodate the cost-sharing subsidies offered to eligible enrollees with incomes below 250 percent of FPL. Thus, each marketplace silver-level plan has a standard 70 percent actuarial value structure as well as variants with actuarial values of 94 percent, 87 percent, and 73 percent. In Table 4 we present deductibles and out-of-pocket maximums for coverage for a single adult associated with the benchmark plan in each of our

10 study cities, along with the deductibles and out-of-pocket maximums for the cost-sharing reduction plans associated with that benchmark plan.

Predicting the structure of health insurance plans that would be offered under the AHCA compared with those offered under the ACA is challenging, and we do not attempt to do that in this brief. However, because the AHCA would provide more flexibility to insurers in the design of their nongroup insurance plans and in the actuarial value of those plans, deductibles and out-of-pocket maximums can be expected to be significantly higher under the AHCA than those associated with silver-level plans under the ACA. The AHCA does not provide for any cost-sharing subsidies for lower-income enrollees. Thus, comparing the cost-sharing requirements of standard ACA silver-level plans to cost-sharing requirements in cost-sharing reduction plans very likely understates the difference in the out-of-pocket liabilities that people with modest incomes would face under the AHCA versus the ACA.

The deductibles and out-of-pocket maximums for benchmark plans vary across the study cities, as do co-payments and co-insurance; the latter are not shown for simplicity. There are many ways for an insurer to construct a plan with a particular actuarial value. It could use higher deductibles but lower out-of-pocket maximums, or it could offer no deductible but higher co-payments or co-insurance. Taking all cost-sharing requirements into account, however, each benchmark silver plan has a computed actuarial value within the range of 68 to 72 percent. Across the study cities, deductibles for single coverage in the benchmark silver-level plans under the ACA range from \$2,400 (in Detroit) to \$5,500 (in Cleveland), and out-of-pocket maximums range from \$6,500 (in Cleveland) to \$7,150 (in Detroit, Providence, Charleston, and Charlotte). As noted, these standard cost-sharing requirements are likely smaller than what would be typical for plans under the AHCA, but they provide a first-order sense of the increased out-of-pocket liability that low-income people would face under the AHCA compared with the ACA.

Eligible marketplace enrollees with incomes below 150 percent of FPL can receive a 94 percent actuarial value plan for the premium contribution required of a standard silver-level plan. The benchmark 94 percent actuarial value plans in Cleveland, Detroit, and Providence have no deductibles (Table 4). In the other markets, deductibles range from \$75 to \$575. These

reduced requirements lower deductibles for this income group by \$2,400 to \$5,925 depending upon the city. Those with incomes between 150 and 200 percent of FPL are eligible for 87 percent actuarial-value plans, and these lower deductibles by \$1,850 to \$5,050 depending upon the city. Even the much more modest 73 percent actuarial-value plans offered to those with incomes between 200 and 250 percent of FPL can lead to substantially reduced deductibles (up to reductions of \$2,000) depending upon the city and the plan structure.

Out-of-pocket maximums are also much lower for low-income marketplace enrollees under the ACA (Table 4). This is particularly true for those with incomes below 200 percent of FPL who are eligible for the largest cost-sharing reductions

(i.e., the highest actuarial-value plans). Enrollees in 94 percent actuarial-value plans have their total yearly out-of-pocket liabilities reduced by \$4,400 to \$6,400 depending upon the city. Those enrolled in 87 percent actuarial value plans have their total yearly out-of-pocket liability reduced by \$4,400 to \$5,850, again depending upon the city. Even those eligible for 73 percent actuarial-value plans have their potential costs lowered by \$950 to \$2,600. Again, these lowered liabilities are most likely significant underestimates of the differences between ACA and AHCA out-of-pocket liabilities for these low-income people because the AHCA would permit lower actuarial-value plans than does the ACA, and the AHCA would provide no cost-sharing assistance.

Table 4. Comparison of ACA Marketplace Deductibles and Out-of-Pocket Maximums for Selected Cities' Benchmark Plan, 2017

Deductibles							
	70% AV (standard)	94% AV	87% AV	73% AV	Difference between standard and 94% AV	Difference between standard and 87% AV	Difference between standard and 73% AV
Cleveland	\$5,500	\$0	\$450	\$3,500	\$5,500	\$5,050	\$2,000
Detroit	\$2,400	\$0	\$500	\$2,275	\$2,400	\$1,900	\$125
Seattle	\$6,500	\$575	\$1,750	\$5,000	\$5,925	\$4,750	\$1,500
Providence	\$3,000	\$0	\$500	\$3,000	\$3,000	\$2,500	\$0
Los Angeles	\$2,500	\$75	\$650	\$2,200	\$2,425	\$1,850	\$300
Birmingham	\$2,600	\$100	\$400	\$1,750	\$2,500	\$2,200	\$850
Oklahoma City	\$4,000	\$250	\$500	\$3,800	\$3,750	\$3,500	\$200
Tucson	\$4,000	\$75	\$1,000	\$3,000	\$3,925	\$3,000	\$1,000
Charleston, WV	\$3,500	\$250	\$700	\$3,000	\$3,250	\$2,800	\$500
Charlotte	\$5,000	\$500	\$1,000	\$3,000	\$4,500	\$4,000	\$2,000
Out-of-Pocket Maximums							
	70% AV (standard)	94% AV	87% AV	73% AV	Difference between standard and 94% AV	Difference between standard and 87% AV	Difference between standard and 73% AV
Cleveland	\$6,500	\$700	\$2,250	\$5,450	\$5,800	\$4,250	\$1,050
Detroit	\$7,150	\$1,250	\$2,250	\$5,700	\$5,900	\$4,900	\$1,450
Seattle	\$6,500	\$515	\$1,750	\$5,000	\$5,985	\$4,750	\$1,500
Providence	\$7,150	\$1,150	\$2,250	\$5,500	\$6,000	\$4,900	\$1,650
Los Angeles	\$6,800	\$2,350	\$2,350	\$5,700	\$4,450	\$4,450	\$1,100
Birmingham	\$6,850	\$450	\$1,000	\$4,250	\$6,400	\$5,850	\$2,600
Oklahoma City	\$6,850	\$600	\$2,000	\$5,700	\$6,250	\$4,850	\$1,150
Tucson	\$6,650	\$2,250	\$2,250	\$5,700	\$4,400	\$4,400	\$950
Charleston, WV	\$7,150	\$1,250	\$2,000	\$5,700	\$5,900	\$5,150	\$1,450
Charlotte	\$7,150	\$800	\$2,350	\$5,700	\$6,350	\$4,800	\$1,450

Note: AV = actuarial value.

CONCLUSION

The AHCA tax credits are designed to be simple and easy to understand: they vary with age and are consistent across incomes until \$75,000 for single people and \$150,000 for families. The ACA tax credits are more complicated and are equal to the difference between the second-lowest-cost (benchmark) silver-level plan premium and a defined percentage of income, with the percentage of income increasing as income rises and with no assistance for those with income of 400 percent of FPL or higher. We find that the AHCA tax credits tend to be higher than the ACA tax credits for higher-income people and younger adults living in low-premium areas. Lower-income older adults receive higher tax credits under the ACA than they would under the AHCA regardless of whether they live in high-premium or low-premium areas. The design of the ACA's credits means that they increase when needed: they are higher for low-income people, older adults, and for people living in higher-premium markets. Further, the cost-sharing assistance under by the ACA provides substantial additional financial protection for lower-income enrollees; the AHCA offers no such assistance.

Tax credits that vary with age alone (or, as under the AHCA, that only decrease once income crosses a high threshold) cannot target government assistance to those with the greatest need. To provide a tax credit that meets the needs of those living in higher-premium areas without varying credit amounts geographically, additional assistance would need to be provided across the country, leading to much more

government spending than under the AHCA or the ACA. To provide age-related assistance across the income distribution (or across much of the income distribution) without varying the credits by income, larger tax credits would need to be provided to all if adequate coverage is to be affordable to the low-income population. That could be done, but the government costs would again be much higher than under the ACA or the AHCA.

High-premium insurance markets typically reflect limited insurer or provider competition.³ Nothing in the AHCA would change this dynamic, and therefore geographic premium differences like those under current law would remain. Further, reduced regulation of insurance plan standards under the AHCA would lead to different plans being offered by insurers than are offered under the ACA. Under the AHCA, benefits can be expected to be narrower and cost-sharing requirements greater. Although such changes in offered plans could lead to lower premiums (absent a worsening risk pool), the trade-off would be higher out-of-pocket requirements and more services excluded entirely from insurance coverage and left for people to pay for fully when needed. The differences in financial assistance offered under the ACA and the AHCA could play out into much greater differences in financial burdens for people with health problems versus those without them and for those in states that regulate insurance to a greater extent than those in states that do not.

ENDNOTES

1. Kaiser Family Foundation. *Premiums and Tax Credits Under the Affordable Care Act vs. the American Health Care Act: Interactive Maps*. Menlo Park, CA: Kaiser Family Foundation, 2017. <http://kff.org/interactive/tax-credits-under-the-affordable-care-act-vs-replacement-proposal-interactive-map/>.
2. Cohn N. Trump Supporters Have the Most to Lose in the G.O.P. Repeal Bill. *New York Times*. March 10, 2017. <https://www.nytimes.com/2017/03/10/upshot/why-trump-supporters-have-the-most-to-lose-with-the-gop-repeal-bill.html>. Accessed May 5, 2017.
3. Holahan J, Blumberg LJ, Wengle E and Solleveld P. *What Explains the 21 Percent Increase in 2017 Marketplace Premiums, and Why Do Increases Vary Across the Country?* Washington, D.C.: Urban Institute, 2017. <http://www.urban.org/research/publication/what-explains-21-percent-increase-2017-marketplace-premiums-and-why-do-increases-vary-across-country>; and Holahan J, Blumberg LJ and Wengle E. Characteristics of Marketplaces with One or Two Insurers. Washington, D.C.: Urban Institute, forthcoming.

Copyright© May 2017. The Urban Institute. Permission is granted for reproduction of this file, with attribution to the Urban Institute.

About the Authors and Acknowledgements

John Holahan is an Institute Fellow, Linda Blumberg is a Senior Fellow, and Erik Wengle is a Research Associate in the Urban Institute's Health Policy Center. The authors appreciate the comments and suggestions of Stephen Zuckerman.

About the Robert Wood Johnson Foundation

For more than 40 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working with others to build a national Culture of Health enabling everyone in America to live longer, healthier lives. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.

About the Urban Institute

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector. For more information, visit www.urban.org. Follow the Urban Institute on [Twitter](#) or [Facebook](#). More information specific to the Urban Institute's Health Policy Center, its staff, and its recent research can be found at www.healthpolicycenter.org.