Center for Health and Economy

The Patient Choice, Affordability, Responsibility, and Empowerment Act

January 30, 2014

In January 2014, Senators Richard Burr (NC), Tom Coburn (OK), and Orrin Hatch (UT) made public a proposal—the Patient Choice, Affordability, Responsibility, and Empowerment (CARE) Act. The CARE Act would repeal the Patient Protection and Affordable Care Act of 2010 (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA)—with the exception of all provisions relating to Medicare—and replace it with several reforms. Key provisions include a premium credit for all individuals earning less than 300 percent of the federal poverty limit, a cap on tax-exempt income spent on employer sponsored health insurance, and a capped allotment funding design for Medicaid, among others. This report details the findings of the Center for Health and Economy's (H&E) Under-65 Microsimulation Model on the proposal's impact on health insurance premium prices, insurance coverage, patient access to providers, medical productivity, and the federal budget. While our estimates are associated with some degree of uncertainty, the summary of our findings is as follows:

- **Premium Impact:** The CARE Act is projected to produce lower average premiums when compared to current law. Narrow network and PPO insurance products for single coverage are estimated to experience the largest premium reductions.

- **Coverage Impact:** The number of insured individuals under the proposal is projected to be nearly equal to current law in 2017. By 2023, the number of insured under the proposal in estimated to be 1 percent higher than under current law. In 2017, the proposal is estimated to yield a 17 percent decrease in the Medicaid population compared to current law. By 2023, H&E estimates there will be 30 percent more enrollees in the individual insurance market and 2 percent fewer enrollees in the employer sponsored insurance market under the CARE Act when compared to current law.

- **Provider Access:** The CARE Act is projected to result in similar patient access to providers (measured by the H&E Provider Access Index) as under current law. The average provider access in the individual market is expected to decline under the CARE Act. However, a reduced reliance on Medicaid is projected to offset the decline in the individual market, leading to the same average provider access for the under-65 population as under current law.

- **Medical Productivity:** The CARE Act is expected to lead to 2 – 3 percent greater medical productivity (measured by the H&E Medical Productivity Index) as compared to current law in 2017. This reflects the proposal's ability to reduce health costs while maintaining or increasing the quality of health output.

- **Budget Impact:** Compared to current law, the proposal will yield an estimated 10-year net savings of $1,473 billion.

Center for Health and Economy

Microsimulation Analysis

This analysis utilizes a microsimulation model developed for use by the Center for Health and Economy. 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.[1] The key policies and assumptions used by H&E to analyze the CARE Act are as follows:

- The CARE Act becomes effective on January 1, 2017.
- PPACA and HCERA are repealed with the exception of any provisions relating to Medicare.
- A group health plan or health insurance issuer offering group or individual health insurance coverage may not establish lifetime limits on the dollar value of benefits for any participant or beneficiary.
- A group health plan or health insurance issuer offering group or individual health insurance coverage will provide guaranteed issue for all enrollees with continuous coverage.
- In the first year of implementation, there will be a national open enrollment period for health insurance not longer than 6 months. During this period, health plans must offer a policy and may not discriminate with regard to health status or pre-existing condition.
- Insurers are required to offer coverage to people who have stayed continuously insured, without exclusions for pre-existing conditions, and at standard rates based on age and residence.
- An older individual will pay no more than 5 times what a young individual pays for health insurance premiums in all states.[2]
- Health insurance plans are required to continue to cover dependents until age 26 in all states.[3]
- States have high-risk pools that are leveraged and enlarged with limited federal funding.
- Individuals and families earning less than 200 percent of the federal poverty level (FPL) are eligible for an age-adjusted health insurance premium credit with the following in 2013 dollars, indexed by one percentage point higher than the Consumer Price Index (CPI+1):

Age	Individual	Family
18 - 34	$1,560	$3,400
35 - 49	$2,530	$6,615
50 - 64	$3,720	$8,810

- Individuals and families earning more than 200 percent of FPL are eligible for a partial subsidy, phased down to zero at 300 percent of FPL.
- Employees of firms with less than 100 full time equivalent employees are eligible to receive a refundable tax credit which they can use to buy insurance through the individual market.
- Small group and individual market pooling in order to facilitate lower premiums is allowed.

[1] More information on the H&E Under-65 Microsimulation Model can be found at http://healthandeconomy.org/models/under-65-microsimulation/

[2] The proposal allows states the option to opt-out of this policy. H&E assumes that no states will choose to opt-out.

[3] *ibid*

- States receive Medicaid funding through capped allotments. States would continue to receive pass-through funding for pregnant women, low-income children, and low-income families. States also receive a defined budget for long-term care services for low-income elderly or disabled individuals choosing not to use the health insurance premium credit.
- States have the authority to auto-enroll Medicaid eligible residents.
- The tax exclusion for employer sponsored health insurance (ESI) premiums is capped. The value of ESI plans in excess of the tax exclusion cap is subject to income and payroll taxation. For this analysis we assume a tax on those who choose health insurance benefits greater than $5,400 for single coverage and $11,250 for family coverage, in 2013 dollars, equal to the employee's marginal income tax rate times the amount over those thresholds. These thresholds are indexed to CPI + 1.
- Active duty military, veterans, and Native Americans are eligible to contribute towards a health savings account (HSA).
- The definition of "qualified health expenditure" for HSAs is expanded to include insurance premiums and over the counter medications.
- New protections are granted to HSAs, such as bankruptcy protections equivalent to retirement funds.

In this analysis, H&E uses other economic literature to target the effects of policies the microsimulation is not adequately able to capture:

- Research suggests that ending the practice of defensive medicine can result in health care expenditure savings.[4]
- The Congressional Budget Office finds that reducing lawsuit abuse can create savings in the federal budget.[5]

[4] Avraham, Ronen et al, "The Impact of Tort Reform on Employer-Sponsored Health Insurance Premiums," Working Paper Series, National Bureau of Economic Research, September 2009; Congressional Budget Office, "Limit Medical Malpractice Torts," November 13, 2013;
[5] Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," p.56, March 2011

Center for Health and Economy

Premium Impact

The CARE Act is expected to lower premiums in all categories of insurance compared to current law. By 2023, the proposal is expected to yield substantially lower premiums than current law in individual insurance product categories with savings of 2 – 11 percent for single policies. H&E predicts that family policies will see a modest decrease ranging from 0.3 – 1 percent. In both categories of coverage, health savings accounts and high deductible health plans (HAS/HDHP) see the smallest premium decrease compared to current law. This is in part because the proposal extends subsidies to anyone who wishes to enroll in this type of plan, whereas current law does not subsidize these plans and penalizes any enrollees over the age of 30.

Annual Premiums Under the CARE Act (in thousands)

	2014	2015	2016	2017	2018	2023
Single Policy						
High PPO	$6.8	$7.0	$7.3	$7.1	$7.5	$10.2
Medium PPO	$6.0	$6.2	$6.5	$6.3	$6.6	$9.0
Low PPO	$5.2	$5.3	$5.6	$5.4	$5.7	$7.7
Narrow Network	$4.1	$4.0	$4.0	$3.8	$3.8	$4.5
HSA/HDHP	$4.5	$4.3	$4.3	$4.7	$4.6	$6.0
Family Policy						
High PPO	$19.4	$20.4	$21.5	$22.8	$24.1	$32.4
Medium PPO	$17.2	$18.0	$19.0	$20.1	$21.2	$28.6
Low PPO	$15.1	$15.7	$16.6	$17.6	$18.5	$25.0
Narrow Network	$12.0	$12.2	$12.5	$12.9	$13.1	$15.2
HSA/HDHP	$14.8	$14.9	$15.3	$16.4	$16.9	$21.7

Percent Change from Current Law

	2014	2015	2016	2017	2018	2023
Single Policy						
High PPO	0.0%	0.0%	0.0%	-8.2%	-9.6%	-9.2%
Medium PPO	0.0%	0.0%	0.0%	-8.2%	-9.8%	-9.4%
Low PPO	0.0%	0.0%	0.0%	-8.3%	-10.1%	-9.7%
Narrow Network	0.0%	0.0%	0.0%	-8.9%	-11.2%	-11.0%
HSA/HDHP	0.0%	0.0%	0.0%	3.0%	-2.6%	-2.5%
Family Policy						
High PPO	0.0%	0.0%	0.0%	0.0%	-0.6%	-0.5%
Medium PPO	0.0%	0.0%	0.0%	0.0%	-0.6%	-0.5%
Low PPO	0.0%	0.0%	0.0%	0.0%	-0.7%	-0.6%
Narrow Network	0.0%	0.0%	0.0%	0.0%	-1.0%	-1.0%
HSA/HDHP	0.0%	0.0%	0.0%	2.1%	-0.3%	-0.3%

Center for Health and Economy

Coverage Impact

The CARE Act achieves nearly equal gains in the number of insured persons compared to current law. By 2023, the proposal is projected to achieve a slight increase in coverage of 1 percent over current law. A significant increase in individual market participation is facilitated by more widely applicable premium credits—enrollees in high deductible plans and enrollees earning below the federal poverty level are eligible under the CARE Act. However, the increase in coverage through the individual market is expected to be offset by large reductions in the Medicaid population.

Insurance Coverage Under the CARE Act (in millions)

	2014	2015	2016	2017	2018	2023
Individual	**41.2**	**42.2**	**42.3**	**49.2**	**49.8**	**48.3**
High PPO	9.5	8.3	7.1	4.2	2.9	0.3
Medium PPO	1.8	1.5	1.2	0.1	0.1	0.0
Low PPO	0.0	0.0	0.0	0.0	0.0	0.0
Narrow Network	22.8	25.2	26.8	37.8	39.9	40.8
HSA/HDHP	7.1	7.1	7.2	7.0	7.0	7.1
Employer	**157.7**	**157.8**	**157.5**	**156.4**	**155.5**	**147.0**
HMO	7.4	7.4	7.5	7.6	7.5	7.3
HRA	11.8	11.8	11.9	12.1	12.1	11.7
HSA/HDHP - Employer Pay	6.1	6.9	7.8	8.8	9.9	17.5
HSA/HDHP - Employee Pays	0.7	1.7	2.3	2.5	3.7	6.1
Narrow Network	7.6	8.3	8.9	7.3	7.8	7.8
PPO High	29.1	28.2	27.4	26.7	25.6	18.9
PPO Low	1.6	1.7	1.8	2.0	2.2	3.0
PPO Medium	93.5	91.7	90.0	89.2	86.7	74.7
Medicaid	**45**	**46**	**47**	**40**	**41**	**49**
Total Insured	**243**	**245**	**246**	**245**	**246**	**244**

Coverage Impact (cont.)

Percent Change from Current Law

	2014	2015	2016	2017	2018	2023
Individual	**0%**	**0%**	**0%**	**18%**	**21%**	**30%**
High PPO	0%	0%	0%	-30%	-44%	-80%
Medium PPO	0%	0%	0%	-88%	-89%	-92%
Low PPO	0%	0%	0%	58%	47%	12%
Narrow Network	0%	0%	0%	38%	43%	47%
HSA/HDHP	0%	0%	0%	-3%	-5%	-6%
Employer	**0%**	**0%**	**0%**	**0%**	**-1%**	**-2%**
HMO	0%	0%	0%	1%	0%	-2%
HRA	0%	0%	0%	1%	-1%	-3%
HSA/HDHP - Employer Pay	0%	0%	0%	0%	0%	0%
HSA/HDHP - Employee Pays	0%	0%	0%	3%	44%	98%
Narrow Network	0%	0%	0%	-17%	-12%	-12%
PPO High	0%	0%	0%	1%	1%	0%
PPO Low	0%	0%	0%	1%	0%	0%
PPO Medium	0%	0%	0%	0%	-1%	-5%
Medicaid	**0%**	**0%**	**0%**	**-17%**	**-16%**	**-11%**
Total Insured	**0%**	**0%**	**0%**	**0%**	**0%**	**1%**

Provider Access

With respect to patient's access to their providers of choice, the CARE Act is expected to achieve similar access to current law, based on the H&E Provider Access Index (PAI).[6] The proposal is projected to reduce the average PAI in the individual market, due to an influx of consumers enrolling in low-cost narrow network plans. However, that reduction is offset by a reduced reliance on Medicaid to insure the low-income population.

Provider Access Index (PAI) Under the CARE Act

	2014	2015	2016	2017	2018	2023
Individual				2.2	2.1	2.0
Employer				3.8	3.8	3.8
Medicaid				1.0	1.0	1.0
Total Insured				**3.0**	**3.0**	**2.9**

Provider Access Index (PAI) Under Current Law

	2014	2015	2016	2017	2018	2023
Individual	2.9	2.8	2.7	2.6	2.5	2.3
Employer	3.8	3.8	3.8	3.8	3.8	3.8
Medicaid	1.0	1.0	1.0	1.0	1.0	1.0
Total Insured	**3.1**	**3.1**	**3.1**	**3.0**	**3.0**	**2.9**

[6] Information on the PAI is available on our website: http://healthandeconomy.org/models/provider-access-index/

Medical Productivity

In general, the CARE Act is expected to result in higher medical productivity, as measured by the H&E Medical Productivity Index (MPI).[7] Increased enrollment in high deductible plans, which are associated with higher medical productivity, and a smaller Medicaid population are the primary causes of a higher MPI under the proposal. As premiums increase over time, consumers are projected to shift towards higher deductible plans, leading to a rise in MPI throughout the analysis period.

Medical Productivity Index (MPI) Under the CARE Act

	2014	2015	2016	2017	2018	2023
Individual				3.1	3.1	3.1
Employer				2.4	2.4	2.6
Medicaid				1.5	1.5	1.5
Total Insured				**2.4**	**2.4**	**2.5**

Medical Productivity Index (MPI) Under Current Law

	2014	2015	2016	2017	2018	2023
Individual	2.9	2.9	3.0	3.0	3.0	3.2
Employer	2.3	2.3	2.4	2.4	2.4	2.5
Medicaid	1.5	1.5	1.5	1.5	1.5	1.5
Total Insured	**2.3**	**2.3**	**2.3**	**2.3**	**2.3**	**2.4**

[7] Information on the MPI is available on our website: http://healthandeconomy.org/models/medical-productivity-index/

Center for Health and Economy

Budget Impact

Compared to current law, the CARE Act is projected to generate $1,473 billion in taxpayer saving over 10 years. Much of these savings are generated by reducing the employer-sponsored insurance tax-exclusion and reforming Medicaid.

Spending Projections Under the CARE Act (in billions)

	2014	2015	2016	2017	2018	2023	10 Year
Medicaid Reform	$0	$0	$0	$28	$29	$25	$193
Medical Malpractice Reform	$0	$0	$0	$5	$6	$8	$45
Tax Revenue	$6	$9	$10	$189	$196	$226	$1,485
Other Federal Spending	-$234	-$245	-$253	-$206	-$218	-$268	-$2,389
Net Budget Effect	**-$229**	**-$236**	**-$243**	**$16**	**$13**	**-$9**	**-$666**

* Positive numbers denote budget surplus and negative numbers denote budget deficit.

Budget Impact of the CARE Act (in billions)

	2014	2015	2016	2017	2018	2023	10 Year
Medicaid Reform	$0	$0	$0	$28	$29	$25	$193
Medical Malpractice Reform	$0	$0	$0	$5	$6	$8	$45
Tax Revenue	$0	$0	$0	$177	$143	$148	$1,057
Other Federal Spending	$0	$0	$0	$52	$46	-$7	$178
Net Budget Effect	**$0**	**$0**	**$0**	**$262**	**$224**	**$174**	**$1,473**

* Positive numbers denote budget surplus and negative numbers denote budget deficit.