Op-Ed

The Economics and Politics of the American Health Care Act

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ON MAY 4TH, THE HOUSE OF REPRESENTATIVES PASSED THE American Health Care Act (AHCA) by a vote of 217 to 213 with 20 Republicans (mostly moderates from the Northeast and Midwest) and all the Democrats voting against it. The legislation, which would replace some but not all of the Affordable Care Act (ACA), has moved on to the Senate, although the Senate leadership has indicated it plans to develop its own legislation rather than work from the legislation passed by the House. The Republican Senate majority is so narrow (52-48) that more than two defections means that even legislation that otherwise meets the requirements to be considered a reconciliation budget measure could not be passed by the Senate without Democratic support.

One major provision of the AHCA is advancing, refundable tax credits, ranging from \$2,000 to \$4,000, based on age rather than income and which start to decline after an individual's income exceeds \$75,000 or a family's income exceeds \$150,000. These credits are in place of the income-related subsidies currently available in the ACA for people who are not on Medicare or Medicaid, who don't have employer-sponsored insurance, and whose income is less than 4 times the federal poverty line. A 30% surcharge could be levied by insurers on individuals who don't maintain continuous insurance coverage and who want to purchase insurance at a later time. This is in place of the much-maligned individual mandate.

In addition, the enhanced Medicaid match rates for all new enrollees after 2020 (which had been at 100% from 2014 to 2016, are currently at 95%, and are scheduled to decline to 90% by 2020) would be replaced by the existing matching rate for each state for the base Medicaid population, varying between 50% and 73%. Medicaid would also be converted to a per capita block grant program or would be available as a straight block grant after 2020.

A stability fund would be established for the states to help develop high-risk pools and other strategies to help insure high-risk individuals. States would also be allowed to opt out of some of the current protections that are part of the ACA, provided that the state set up a high-risk pool for its high-risk individuals. These “opt outs” would allow insurers to modify the essential benefit package, allow a wider variation in premium charges based on age and health status, and allow insurers to not enforce the 1-year 30% surcharge on people who want insurance coverage but don’t maintain continuous coverage.

The House passed the legislation before receiving an assessment from the Congressional Budget Office (CBO) of how the legislation would affect the number of uninsured, deficit spending, or the average price of premiums. Soon after, the CBO provided numbers very similar to the CBO “score” for the previous version of the AHCA that had been under consideration in late March.¹ The CBO estimated that the version of the ACHA passed in May would increase the number of uninsured by 14 million in 2018 and by 23 million in 2026. Spending on Medicaid would decline by \$834 billion over 10 years but, with the decline in revenue from canceling the various ACA excise taxes and taxes on higher income individuals, the deficit would be reduced by only \$119 billion over 10 years. Average spending on premiums would decline modestly.

As frequently happens, the CBO estimates have been controversial, especially for Republicans. Much of the increased number of uninsured comes from the CBO’s assumption that without mandates on individuals and employers, many more people would end up uninsured. The reduction in Medicaid funding from lowering the enhanced Medicaid match would substantially affect the number of uninsured since Medicaid has provided coverage for the majority of newly insured individuals under the ACA.

Several analysts supporting Republican positions note how much the CBO overestimated the number of people who would get their coverage from the exchanges.² CBO forecasts for 2017, for example, anticipated 15 million people getting insurance in the exchanges while the actual number at the end of the 2017 open enrollment was 10.4 million. What these analysts don’t point out, however, is that the predicted total reduction in the uninsured has turned out to be relatively close to current estimates in the reduction of uninsured. The uptake (and spending) on Medicaid has been far greater than was anticipated while the purchase of private insurance in the exchanges has been smaller. A 100% federal

match in dollars was sufficient to bring in 31 states and produce higher than expected spending. Nineteen states remain “hold outs” and have not expanded their Medicaid coverage.

The CBO has historically given more credence to legislation that relies on mandates and administered pricing than it does to changing incentives as a way to change behavior, substantially overestimating the cost of Medicare Part D, a program that relies on competition between private drug plans rather than administered pricing for individual drug purchases. But while the CBO may overestimate the effect on the number of people who would become uninsured without the use of mandates, the numbers are directionally correct. Substantially fewer people would have insurance coverage—because of the smaller subsidies for people just above the Medicaid cutoff, the large reduction in Medicaid spending, and to some extent the elimination of mandates.

There are several challenges to Republicans trying to craft health care legislation that will produce desirable results with an affordable cost. Conservatives have been concerned about using income-related tax credits because of fears that the implicit marginal tax rates—that is, the loss in subsidies as income rises—would dampen work incentives for lower-income workers whose ties to the labor force may be weaker than middle- or upper-income workers. Lower-income individuals receiving larger income-related credits are likely to be on other programs that also decline with income—food stamps, housing support, the earned-income tax credit, etc. When taken together, they could make earning additional money very unattractive. But unfortunately there is no way to provide adequate support to low-income people without income relating the subsidy, unless cost is of no concern. Conservatives also don’t like mandates but it is impossible to protect against preexisting conditions, which many want to do, without strongly encouraging people to carry insurance or pay a penalty if they don’t. The problem with the 30% surcharge is that it doesn’t vary according to how long the person had been without insurance—not that it is too high.

There is also concern among moderate Republicans in both the House and the Senate that the Medicaid match reduction occurs too fast. Rather than going back to the base Medicaid match rates, these congressmen need some compromise between the higher rates and the base rates. For other conservatives, however, the reductions don’t occur fast enough.

In the meantime, the ACA is the law of the land and will remain so until alternative legislation is passed. It behooves Republicans not

to exacerbate the churn and disruption that has been ongoing in the exchanges until alternative legislation is in place and ready to be implemented. Controlling the White House, House, and Senate, even with precarious margins, will make it difficult to convince the American public that any problems with health care aren't the Republicans' responsibility.

References

1. Congressional Budget Office. HR 1628, the American Health Care Act, Incorporating Manager's Amendments 4, 5, 24, and 25. <https://www.cbo.gov/publication/52516>. Published March 23, 2017. Accessed June 5, 2017.
2. Turner G-M. CBO is Wrong and Its Numbers Shouldn't Deter Needed Reform. *Forbes*. May 26, 2017. <https://www.forbes.com/sites/gracemarieturner/2017/05/26/cbo-is-wrong-and-its-numbers-shouldnt-deter-needed-reform/#14f3ab125871>. Accessed June 5, 2017.

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