Barely Covered: Initial Analysis of Coverage and Affordability Impacts to Consumers under the Proposed Better Care Reconciliation Act

Introduction

This report provides an initial assessment of individual market coverage and affordability under the Better Care Reconciliation Act (BCRA) introduced in the U.S. Senate on June 22, 2017 and amended on June 26.

This Issue Brief seeks to inform policymakers on three interrelated elements of the potential impacts of the BCRA on consumers and the individual market:

1. ***What's the coverage?*** Impact on consumers of moving to a benchmark benefit design based on 58 percent Actuarial Value.
2. ***How affordable is coverage for those receiving financial help?*** Impact on consumers of changes to the subsidy structure.
3. ***How affordable is coverage for those who do not receive financial help?*** Impacts of market changes on consumers who do not get financial help to defray premium and/or out-of-pocket costs.

To provide early insight into these questions, the National Academy for State Health Policy (NASHP), in consultation with Covered California, compared the benefits, deductibles, and maximum out-of-pocket (MOOP) of silver plans offered in California, Ohio and Pennsylvania for 2017 to a benefit design that would meet the benchmark plan value proposed in the BCRA.

Under the Affordable Care Act, subsidies are based on consumers' required income-based premium contributions, adjusted for the cost of a benchmark plan in their region. The ACA uses a silver plan as the benchmark. Silver plans have an average actuarial value (AV) of 70 percent, meaning that on average the health plan pays 70 percent of health care costs incurred based on the plan's essential health benefits package and the consumer pays the rest. Currently, a significant percentage of those who enroll in the silver plan also receive additional subsidies known as cost-sharing reductions (CSRs), which cover much of their out-of-pocket costs like deductibles and copayments.

The BCRA would provide tax credits based on a consumer's required income and age-based premium contribution, adjusted for the cost of a benchmark plan in his or her region. The benchmark would be set not to a silver plan but to a bronze plan with an AV of 58 percent, meaning that the enrollee subsidy would be based on the premium charged for a plan that would cover 58 percent of the average cost of care. Consumers would be required to pay the rest of the cost at the point of care in the form of deductibles, copayments and/or coinsurance. BCRA would also eliminate CSRs within two years, meaning there would be no additional assistance to help low income individuals pay for their out-of-pocket costs.

Because subsidies today are tied to the silver level of coverage, silver plan consumers represent a majority of enrollees in the marketplaces (70 percent on average, nationwide).[1]

1. What's the coverage? Impact on consumers of moving to a benchmark benefit design based on 58 percent Actuarial Value.

To assess the impact on coverage, we compared a selection of 2017 silver plans in California, Ohio and Pennsylvania to a benefit design that would meet the BCRA benchmark AV of 58 percent (see Figure 1. Comparing Silver Tier Coverage to the BCRA Benchmark Coverage). While there is variation among the states' coverage of specific types of care, a few important observations are evident:

- **Deductible for Benchmark Plan More Than Doubles – With New Deductible of $7,350 for an Individual and $14,700 for a Family**
  A plan with a 58 percent AV is projected to have a deductible of $7,350 for an individual and $14,700 for a family, the maximum limits allowed in 2018. This new deductible would be two to three times higher than the $2,500 to $3,500 individual deductibles and $5,000 to $7,000 family deductibles offered at the current benchmark level in the selected silver plans offered by the three states in 2017.[2]

- **Less Coverage**
  In order for a plan to be designated a 58 percent AV benchmark plan, additional costs would have to be shifted to the consumer compared to the 70 percent AV benchmark plan today. This could mean higher deductibles, copayments, and co-insurance. This could also mean that services excluded from the deductible under the ACA's benchmark plan would need to be included in the deductible under BCRA's benchmark plan. For example, in each of the three states reviewed, consumers can access numerous services without needing to meet the deductible – including primary care visits, specialist visits, and outpatient services for mental health and substance abuse. A 58 percent benchmark plan would likely require placing these services under the deductible, requiring consumers to pay 100 percent of their medical expenses for these services until their $7,350 deductible is met. A consumer who does not want a high deductible plan would have to pay the premium difference between the benchmark plan and a plan that provides some coverage prior to meeting the deductible.

- **Higher Prescription Drug Costs**
  California's silver plan in 2017 contains a $250 drug deductible that is separate and lower than the deductible for other services. Consumers pay $15 for a generic prescription, which is not subject to the deductible, while other drug tiers have a flat-dollar copayment after meeting the deductible, and their specialty drug costs are capped at $250 per prescription per month. Comparison plans in Ohio and Pennsylvania also offer generic prescriptions for $15 outside of consumers' combined medical and pharmacy deductible and offer benefit features that cap consumers' financial exposure to specialty drug costs. A 58 percent benchmark plan would likely require placing prescription drug costs under the deductible.

This analysis does not take into account the ability of states under the BCRA to waive Essential Health Benefits (EHBs). To the extent states take that option, consumers could face higher cost sharing for excluded benefits. In their analysis of the BCRA, the Congressional Budget Office and the Joint Committee on Taxation estimate that "the scope of the EHBs would be narrowed through waivers affecting close to half of the population."[3]

Figure 1. Comparing Silver Tier Coverage to the BCRA Benchmark Coverage

ACA Comparison: California, Ohio, and Pennsylvania

	Current ACA Covered California		Current ACA Ohio Marketplace		Current ACA Pennsylvania Marketplace		Sample Benchmark Plan Under BCRA	
Benefit	Silver[1] in California		Silver[2] in Columbus		Silver[3] in Philadelphia		58% AV Plan	
Deductible (individual / family)			$3,500 / $7,000		$2,500 / $5,000		$7,350 / $14,700	
Medical Deductible (individual / family)	$2,500 / $5,000							
Drug Deductible (individual / family)	$250 / $500							
Coinsurance (Member)	20%		20%		varies		0%	
MOOP (individual / family)	$6,800 / $13,600		$7,150 / $14,300		$6,500 / $13,000		$7,350 / $14,700	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Emergency Dept. Facility Fee		$350	X	$400	X	30%	X	0%
Inpatient Facility Fee	X	20%	X	20%	X	30%	X	0%
Inpatient Physician Fee	X	20%	X	20%	X	30%	X	0%
Primary Care Visit		$35		$30		$35	X	0%
Specialist Visit		$70		$65		$70	X	0%
Mental Health/Substance Use Outpatient Services		$35		$30		$70	X	0%
Imaging (CT/PET Scans, MRIs)		$300	X	20%		$250	X	0%
Speech Therapy		$35	X	20%		$60	X	0%
Occupational and Physical Therapy		$35	X	20%		$60	X	0%
Laboratory Services		$35	X	20%		$60	X	0%
X-rays and Diagnostic Imaging		$70	X	20%		$60	X	0%
Skilled Nursing Facility	X	20%	X	20%	X	30%	X	0%
Outpatient Facility Fee		20%	X	20%	X	30%	X	0%
Outpatient Physician Fee		20%	X	20%	X	30%	X	0%
Tier 1 (Generic)		$15		$15		$15	X	0%
Tier 2 (Preferred Brand)	X	$55		$50	X	50%, max $300	X	0%
Tier 3 (Nonpreferred Brand)	X	$80		$100	X	50%, max $400	X	0%
Tier 4 (Specialty)	X	20%		40%	X	50%, max $700	X	0%
Tier 4 Maximum Coinsurance	$250		—		$700		—	

Notes: Covered California sets a statewide silver design. Silver plans in Ohio and Pennsylvania were selected by using Healthcare.gov to identify the plan in the most populous city (Columbus and Philadelphia, respectively) with an individual deductible closest to $3,600, the average 2017 silver deductible for a single policyholder as noted in the Congressional Budget Office analysis of the BCRA (https://www.cbo.gov/publication/52849). Plan names are listed in the footnotes below.

All benefit categories with an "X" in the "Ded" column are subject to the deductible, medical deductible, or drug deductible, and the consumer pays the copayment or coinsurance amount given in the "Amount" column once the deductible is met. Under the 58% AV Plan, the consumer pays the full cost of all services until the deductible/MOOP of $7,350 is met, and then all services are fully covered by the plan (i.e. "0%" in the "Amount" column).

[1] Covered California Silver 70
[2] CareSource Federal Simple Choice Silver
[3] Independence Blue Cross – Keystone HMO Silver

Based on these observations about the reduction in coverage under the proposed BCRA benchmark plan, and noting that more than two-thirds of marketplace enrollees are covered in silver plans today, it is reasonable to assume that many enrollees would want to keep their current level of coverage if the BCRA is enacted. What will happen to consumers who want to keep the silver plan they have?

2. How affordable is coverage for those receiving financial help? Impact on consumers of changes to the subsidy structure.

The premium tax credit structure proposed under the BCRA modifies the basic ACA structure for determining how much individuals or families must contribute to their premiums before they are eligible for a premium tax credit. Under the ACA, individuals at a given income level have the same maximum premium contribution for a benchmark silver plan regardless of their age. The benchmark silver plan is based on the second lowest silver plan available to individuals, depending on where they live and their ages.

The BCRA would modify the current structure in the following ways:

- Add age as a premium contribution factor and increase the maximum contribution from 9.5 percent of income today to over 16 percent of income for individuals 59 and older;
- Reduce the ceiling for receiving subsidies from 400 percent to 350 percent of the federal poverty level; and
- Lower the benchmark plan to which tax credits are tied from a silver level to a 58 percent AV plan.

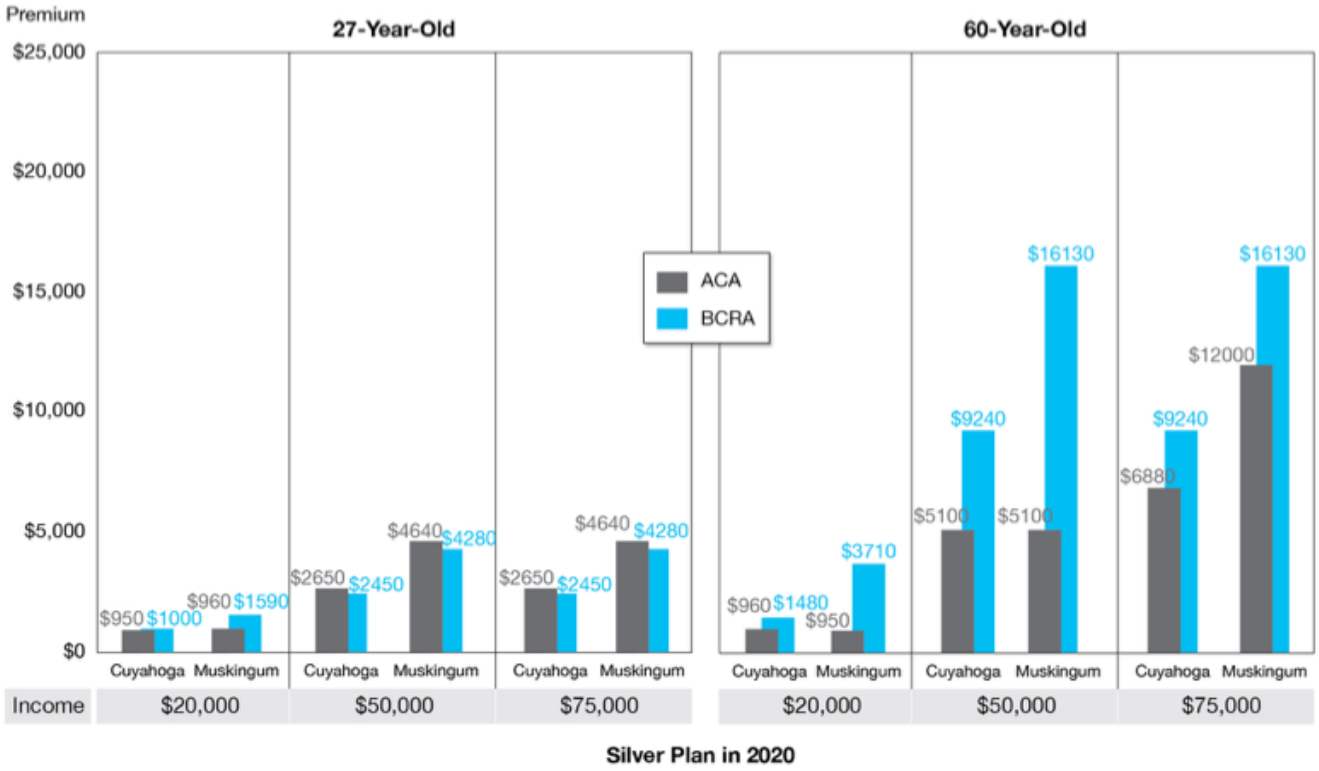
In addition to the tax credit modifications, the BCRA would allow states to permit insurers to charge the oldest enrollees (age 64) five times what the youngest adult enrollees (age 21) are charged for their monthly premiums. Under the ACA, older enrollees cannot be charged more than three times the premium rate for younger enrollees. These factors mean that the BCRA will increase after-subsidy premium costs for many low income and older consumers while reducing costs for younger enrollees.

A previously issued report by NASHP stressed that health care is local.[4] In the following figures, this report shows what it would cost individuals of different ages and income levels to afford the current silver tier coverage in relatively low and high cost areas of the three states reviewed in this analysis. While it is likely that the subsidy structure under the BCRA would incentivize many consumers who currently purchase silver plans to purchase bronze plans, in order to effectively compare affordability of products under the ACA compared to the BCRA, plans of the same metal level must be compared directly. As such, this analysis compares the cost of a silver plan under the ACA to a cost of a silver plan under the BCRA in specific geographic areas, accounting for the age and income of a consumer. While plan offerings could change to some degree under the BCRA compared to under the ACA, the actuarial value standard of a silver plan would remain the same, allowing for a direct comparison in cost.

As indicated in premium estimates from the Kaiser Family Foundation[5], on which the following charts are based, the BCRA tax credit structure would lower net premiums for some younger enrollees in lower cost regions. However, many consumers – especially lower income and older consumers – would see higher net premiums under the BCRA due to the tax credit changes. For example, a 60 year old in Muskingum County, Ohio earning $50,000 per year would see her after-subsidy silver plan premiums increase by more than 216 percent under the BCRA. This effect will be magnified for individuals with incomes below 250 percent of the federal poverty level who will lose access to CSR subsidies that today bring down out-of-pocket costs when they use care.

Figure 2 shows the difference in premium costs for a silver plan under the ACA and the BCRA for a 27 year old and a 60 year old in Cuyahoga County – a relatively low cost county – and Muskingum County – a high cost county.

Figure 2. Comparison of Estimated Annual Consumer Premiums* Under ACA and BCRA for a 27-Year-Old and a 60-Year-Old in a "Low-Cost" and "High-Cost" Ohio County



* Figures are the annual amount a consumer pays for coverage after accounting for premium subsidies. Silver coverage ignores cost-sharing reduction subsidies, which represent additional coverage value to ACA consumers at incomes between $20,000 and $30,000. For total premiums, these estimates assume 3-to-1 age bands specified in the ACA; assumes 5-to-1 band for BCRA except for states that have adopted a narrower requirement.

Major observations from these analyses include:

- The BCRA tax credit formula, without taking into account the CSR subsidies, would lower premiums for some younger enrollees in the parts of the state with lower cost coverage. For example, a 27 year old in Cuyahoga County earning $50,000 per year would save $200 per year for silver plan (or an 8 percent decrease).
- However, many consumers – especially lower income and older consumers – would see higher prices under the BCRA. For example, if that same consumer earning $50,000 per year were a 60 year old, she would see her premium increase by $4,140 per year (an 81 percent increase), from $5,100 under the ACA to $9,240 under the BCRA. If that same consumer happened to live in Muskingum County, that cost would skyrocket from $5,100 under the ACA to $16,130 under the BCRA, an increase of 216 percent.

- Similar effects on net premiums are evident for California and Pennsylvania – the other two comparison states chosen for this Issue Brief. See Appendix 1 and 2 for premium comparisons in these states. Net premiums for relatively low and high cost counties in all states are available on an interactive tool posted on NASHP's website.

3. How affordable is coverage for those who do not receive financial help? Impacts of market changes on consumers who do not get financial help to defray premium and/or out-of-pocket costs.

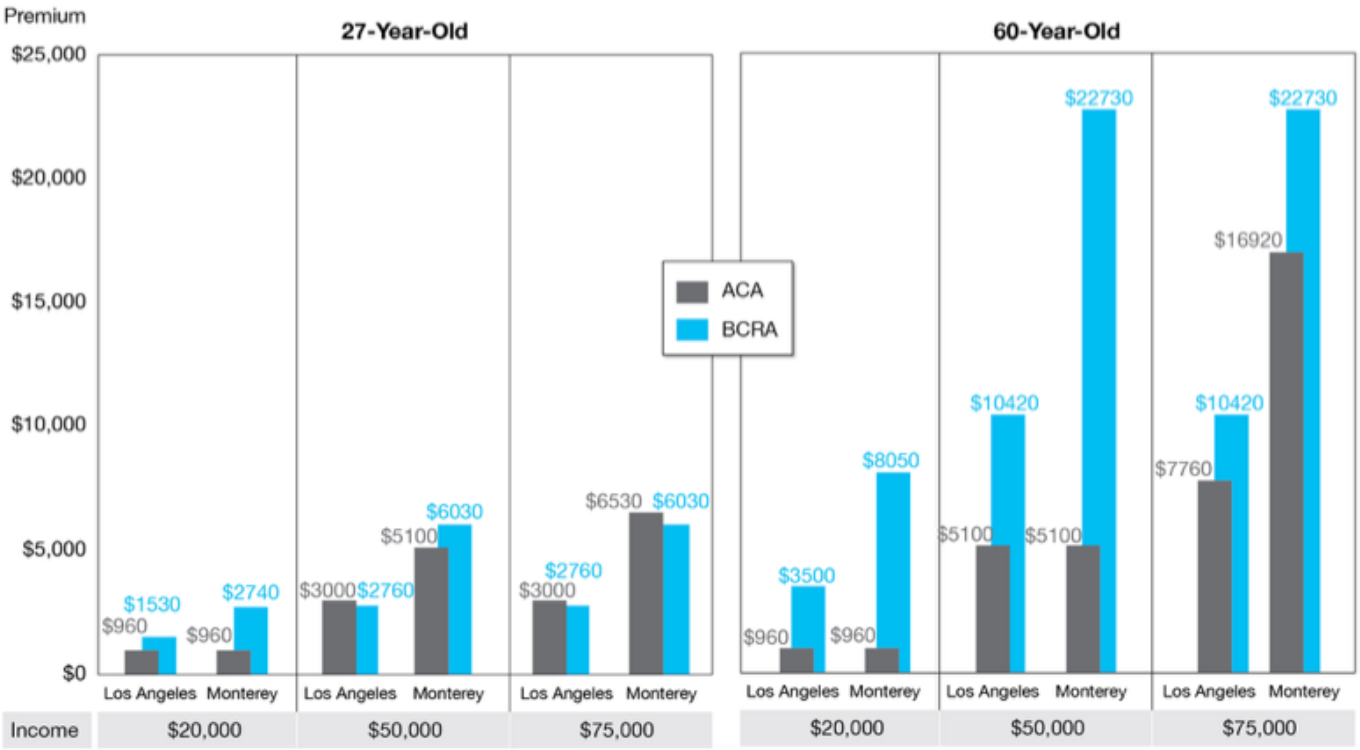
At 400 percent of the federal poverty level under the ACA, and 350 percent of the federal poverty level under the BCRA, consumers' premium contributions are no longer capped and premium tax credits are not available, meaning that these "unsubsidized" consumers bear the full cost of annual premium rate increases from which subsidized consumers are largely insulated.

The impact of the BCRA on the individual market is not known, but by increasing costs for many purchasing silver plans, changing the incentives to purchase coverage ,reducing benefits and subsidies for those purchasing the lower value benchmark plan, and eliminating cost sharing reductions market instability could occur. Further, combining the shift towards lower AV plans with the loss of CSRs, low income consumers would likely struggle to pay the significant out-of-pocket costs for health care services when they need them, even if they were able to afford the monthly premiums. This could result in either consumers declining to seek care at all, or being unable to pay for services after they have been received.

Conclusion

While the Senate debates the merits of the BCRA, a central question that needs to be asked is not just how the bill will impact the number of Americans without health insurance coverage, but for those with health insurance, what will be covered and at what cost. This initial report shows significant reductions in benchmark benefits and tax credit support particularly for lower income and older individuals. The stability funds included in the BCRA may mitigate the negative premium effects of policy changes in 2018 and 2019, but require significant state revenues to match federal contributions in the out years. In the long run states may have to make difficult decisions about how to spend stability funds, and may have to choose between strategies like moderating premium costs for all consumers through ongoing reinsurance, or backfilling for lost CSRs to increase affordability of care and take up for low-income consumers. These potential impacts should be carefully evaluated to determine their likely impact on the stability and long-term viability of the individual insurance market.

Appendix 1. Comparison of Estimated Annual Consumer Premiums* Under ACA and BCRA for a 27-Year-Old and a 60-Year-Old in a "Low-Cost" and "High-Cost" California County



Silver Plan in 2020

* Figures are the annual amount a consumer pays for coverage after accounting for premium subsidies. Silver coverage ignores cost-sharing reduction subsidies, which represent additional coverage value to ACA consumers at incomes between $20,000 and $30,000. For total premiums, these estimates assume 3-to-1 age bands specified in the ACA; assumes 5-to-1 band for BCRA except for states that have adopted a narrower requirement.

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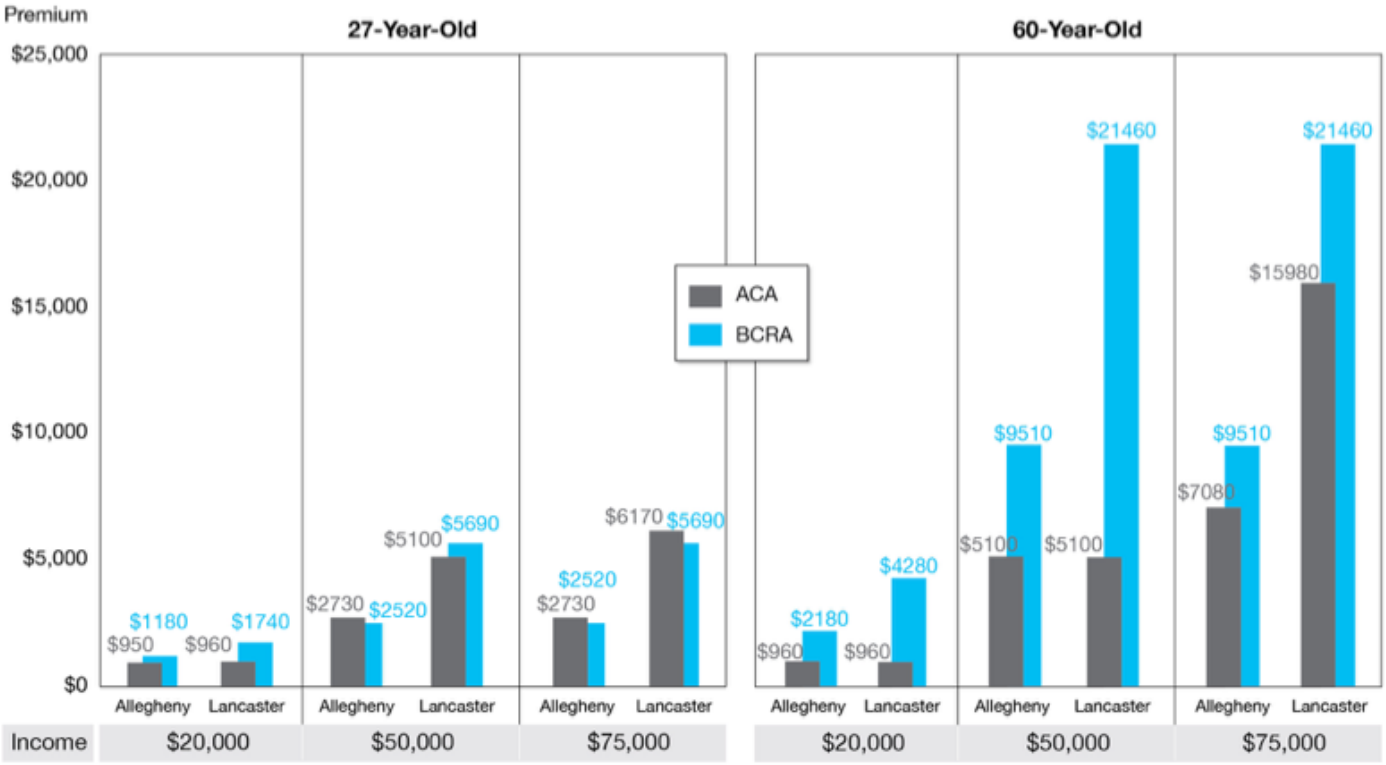

Silver Plan in 2020

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Endnotes

1. For national silver enrollment, see: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html
2. Note that the maximum allowed out of pocket could be higher than $7,350 in 2019 when the 58 percent AV benchmark plan would be developed.
3. Congressional Budget Office Cost Estimate H.R. 1628 Better Care Reconciliation Act of 2017, accessed on June 26, 2017, https://www.cbo.gov/publication/52849
4. Riley, T., Cousart, C., "Health Care is Local: Impact of Income and Geography on Premiums and Premium Support," accessed on June 26, 2017, http://nashp.org/wp-content/uploads/2017/06/Health-Care-is-Local1.pdf
5. The Henry J. Kaiser Family Foundation, Premiums and Tax Credits under the Affordable Care Act vs. the Senate Better Care Reconciliation Act, accessed on June 23, 2017, http://www.kff.org/interactive/premiums-and-tax-credits-under-the-affordable-care-act-vs-the-senate-better-care-reconciliation-act-interactive-maps/

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