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The $33 billion hidden tax in the American Health Care Act—higher deductibles and copays

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SECTIONS

To listen to prominent Republicans asserting the need to tear up the Affordable Care Act (ACA), you would think that health plans under the ACA ask too much from patients in out-of-pocket (OOP) costs, i.e., impose excessive deductibles and copays.

Mediaite.com reported, "In an interview with the Washington Post's Robert Costa, president-elect Donald Trump boasted that the healthcare plan he's working on to replace the Affordable Care Act will have much 'lower numbers, much lower deductibles.'" (Baragona 2017)

A press release from House Speaker Paul Ryan's office asserts that "Obamacare has failed the American people: Premiums are skyrocketing and deductibles are soaring." (Martorana 2017)

On *Face the Nation,* Mitch McConnell said the ACA has resulted in "premiums going up, copayments going up, deductibles going up. And many Americans who actually did get insurance when they did not have it before, have really bad insurance that they have to pay for and the deductibles are so high that it's really not worth much to them." (CBS News 2017)

And HHS Secretary Tom Price told *CNN* he gets "calls almost weekly from my former fellow physicians who tell me that their patients are making decisions about not getting the kind of care that they need because they can't afford the deductible." (CNN 2017)

Yet despite this vociferous complaining about how high OOP costs burden American households under the ACA, the replacement plan that these leaders are pushing would substantially *increase* out-of-pocket costs for these same Americans. The American Health Care Act (AHCA) would cost Americans roughly $33 billion a year in higher out-of-pocket costs by 2026. That means the Republican claim that they want to repeal the ACA and replace it with the AHCA because they want to relieve Americans of too-high OOP costs is a demonstrable lie.

To be very clear, $33 billion is just the additional cost Americans would face in the form of higher deductibles, copays, and coinsurance. Millions would also face substantially higher costs of insurance premiums (and millions will obviously be forced to go without any

insurance at all). But given how ubiquitous is the complaint from Republican policymakers about high OOP costs under the ACA, it is worth focusing on this aspect of the ACA replacement plan (the AHCA) in some detail. The AHCA would boost OOP costs in four broad ways:

1. It eliminates subsidies to help Americans pay OOP costs incurred when they have purchased health insurance through the ACA marketplace "exchanges." By 2026, the elimination of these cost-sharing subsidies will boost OOP costs faced by patients in 2026 by roughly $16 billion per year.
2. It dismantles key regulations that govern the depth of protections offered by insurance policies sold through the ACA exchanges. This will degrade the quality of insurance for all enrollees in nongroup (i.e., individual) markets, regardless of whether they receive subsidies for coverage. By 2026 this degradation of insurance plan quality for all nongroup enrollees will boost OOP costs faced by patients by roughly $9 billion per year.
3. It takes Medicaid coverage away from 14 million Americans in 2026. Because Medicaid recipients face extremely low OOP costs, this shift alone will boost OOP costs faced by patients in 2026 by roughly $7 billion.
4. It moves 7 million Americans off of employer-sponsored insurance (ESI) and into uninsured status. The primary damage done by this move will be to force these 7 million to simply consume much less health care. But even with this reduction in total health care consumed, these 7 million will face higher OOP costs. By 2026, the withdrawal of ESI from 7 million Americans will boost OOP costs faced by patients by roughly $460 million.

Adding up these additional costs gives an overall cost of roughly $33 billion a year.

The ACA and out-of-pocket costs

The Affordable Care Act has substantially *reduced* OOP costs for Americans, particularly those without employer-sponsored insurance. When people complain about allegedly high OOP costs associated with the ACA, they are most often referring to the insurance policies sold through the ACA-established marketplace "exchanges." These exchanges set rules and transparency to impose order on the chaotic market for individual insurance policies that existed pre-ACA, and also served as mechanisms to deliver subsidies to those purchasing health insurance policies and health care.

The major reform that the ACA exchanges made to the nongroup insurance market was requiring that all insurance carriers offer their plans to all customers regardless of health status. Crucially, these plans have to be offered at essentially the same price, with minimal price discrimination allowed by age and smoking status. Older customers may be charged more, but the widest ratio of insurance prices charged to older versus younger enrollees is 3-to-1.

However, another crucial ACA nongroup reform is the ceiling put on expected OOP costs

for plans sold on the exchanges. The ACA mandated minimum "actuarial values" for plans sold on the exchanges, a measure of what share of total expected health spending would be borne by the insurance company rather than the patient. The ACA exchange minimum is 60 percent, and the plans used to calculate the ACA subsidies have a minimum actuarial value of 70 percent. This means that the plans used to calculate ACA subsidies have to provide enough coverage to pay for 70 percent of average expected health costs, with the remaining 30 percent paid by patients.

This is, to be clear, "thinner" insurance with higher deductibles and copays than what is generally offered by employer-sponsored plans. However, it represents a substantial *improvement* over the policies being sold on the nongroup market before the ACA. Researchers have estimated that more than *half* of the plans offered in the nongroup market before the ACA would not have been allowed on ACA exchanges precisely because they demanded too-high OOP costs like high deductibles and copays (Gabel et al. 2012).

Cost-sharing reduction subsidies

Another feature of the exchanges created by the ACA that limit exposure to high OOP costs are cost-sharing subsidies that cap these costs as a share of income. While the subsidies to help pay for insurance *premiums* for plans in the exchanges are available to incomes as high as 400 percent of the federal poverty line (FPL), the cost-sharing subsidies are only available to those with incomes below 250 percent of poverty. Still, these subsidies have relieved literally billions of dollars in OOP costs from exchange enrollees, and, they have made the net-of-subsidy actuarial value for a majority of the plans sold in the exchange actually comparable to those in the ESI market (Sprung 2016).

ACA and Medicaid

The last way that ACA has reduced OOP costs for American patients is through its significant expansion of Medicaid. Medicaid coverage comes with much lower OOP costs, so any expansion of Medicaid is near-guaranteed to reduce OOP costs on average.

AHCA and out-of-pocket costs

Given the intense Republican criticism of the ACA for not providing sufficient protection against high OOP costs, one might expect that reducing these costs would be a prime priority for those looking to reform the American health sector. Solutions to high OOP costs in the ACA are hardly rocket science. The most obvious one is to simply boost the generosity and reach of the cost-sharing subsidies. Further, such increases in generosity could be financed out of measures that would slow health care cost growth across-the-board, like the introduction of bargaining for lower prices in the Medicare prescription drug program, or the liberalization of trade in pharmaceuticals, or more assertive use of the federal government's monopsony power as a health-care purchaser more generally,

perhaps through the introduction of a "public option" as a potential choice in ACA exchanges (Baker 2013, Bivens 2017, Matthews 2015).

The proposed AHCA does none of this. Instead, it would *boost* insurance enrollees' exposure to high OOP costs. It would cost American patients tens of billions in extra OOP costs in coming years. By 2026, the implicit annual tax of higher OOP costs caused by the AHCA would reach *$33 billion*.

AHCA and cost-sharing subsidies

Most obviously, the AHCA does away completely with cost-sharing subsidies. By 2026, this would directly boost OOP costs faced by American patients by roughly **$16 billion** in that year alone. The stripping away of these cost-sharing subsidies is the key reason why the actuarial value of plans available to lower-income exchange enrollees plummets under the AHCA relative to the ACA. In their cost estimate of the AHCA, the Congressional Budget Office (CBO) estimated that exchange enrollees with incomes at 175 percent of the federal poverty line would see the actuarial value of the plans they purchase through the nongroup market falling from 87 percent to 65 percent (CBO 2017, table 4).

AHCA regulatory-stripping degrades insurance for all enrollees, not just lower-income ones

Besides removing cost-sharing subsidies that the ACA provides to all those below 250 percent of the FPL, the AHCA also strips away the minimum actuarial value thresholds for plans sold in the nongroup market (i.e., plans would no longer have to provide coverage and benefits that translate into a minimum actuarial value). This change would degrade the quality of insurance plans for all enrollees in this market, not just those who received cost-sharing subsidies. In a recent analysis, Matthew Fiedler and Loren Adler find that the average actuarial value throughout the nongroup market falls significantly, even *before* the impact of lower cost-sharing subsidies are factored in (Fiedler and Adler 2017).

Specifically, Fiedler and Adler find that average premiums in nongroup markets in 2026 under the AHCA would be $6,815. However, they find that the average actuarial value of plans in the nongroup market would be 65 percent, down from the average actuarial value of 70 percent that prevails under the ACA. Assuming that 80 percent of the cost of premiums reflect underlying claims costs (with the remainder constituting administrative costs and profits), and further assuming that these claims costs cover 65 percent of total health care costs incurred, this implies that *total costs* on average are $8,390 in that year [($6,815*0.8)/0.65]. Total costs *not* covered by insurance (or, OOP costs) hence total $2,935 (35 percent of the total $8,390).

If instead health plan quality had remained at ACA levels (with health plans covering 70 percent, not 65 percent, of expected costs), they find that average premiums would be $7,415. Again assuming that 80 percent of these premiums are spent on underlying claims costs and that insurance-paid claims represent 70 percent of total health costs, this implies

OOP costs of $2,540 ([($7,415*0.8)/0.7]*0.3). All else equal, this implies that the degradation of insurance plan quality spurred by the AHCA boosts OOP costs by $395 per patient. Importantly, their estimates on premium changes (and hence our estimates of OOP changes) *include* any effect that more-generous actuarial value has in spurring greater health care consumption, which could mildly boost OOP costs.

This analysis implies that the degradation of insurance plan quality (i.e., lower actuarial value) induced by the AHCA will cost nongroup enrollees on average an additional $395 in higher OOP in 2026. Multiplying this number by the 23 million nongroup enrollees expected in that year under the AHCA implies $9 billion in higher OOP costs faced by patients due just to this aspect of the AHCA.

Adding this extra $9 billion in OOP costs stemming from reduced plan protectiveness (lower actuarial value) to the $16 billion in higher OOP costs stemming from eliminating subsidies to help pay for OOP costs means that the AHCA would cost enrollees in nongroup insurance markets roughly $25 billion in additional OOP costs each year by 2026—even before the influence of cuts to Medicaid and increases in the number of Americans who are uninsured.

AHCA and Medicaid

Another large boost to OOP costs by the proposed AHCA is driven by cuts to Medicaid. The largest coverage gains under the ACA were due to its Medicaid expansion. Even accounting for the 20 states that refused to agree to this expansion, Medicaid enrollment increased by more than 10 million due to the ACA.

The AHCA rolls back these expansions, and cuts Medicaid by $880 billion over the next 10 years. By 2026, the AHCA would result in 14 million fewer people covered by Medicaid. Because Medicaid provides coverage with virtually no cost-sharing, moving 14 million people off of Medicaid is guaranteed to significantly increase OOP costs. The Kaiser Family Foundation, for example, compared OOP costs for low-income families with and without Medicaid. They find that OOP costs are higher by more than $500 a year for those families without Medicaid. Multiplying this $500 increase in OOP costs for each person who loses Medicaid coverage due to the AHCA implies a $7 billion increase in OOP costs due to the lost Medicaid coverage (Majerol, Tolbert, and Damico 2016).

Again, it is important to be clear that this is only an estimate of the cost of higher deductibles, copays, and coinsurance faced by patients as a result of losing Medicaid coverage. The far greater losses will come in total health care consumed (as many people become unable to afford to purchase any health care at all) and/or the losses incurred because people now have to pay for premiums for private insurance.

AHCA and employer-sponsored insurance

Finally, CBO estimates that the AHCA will result in 7 million people losing employer-sponsored insurance. This loss stems in part from the rollback of the individual mandate in

the ACA that required all Americans to maintain some health insurance. This loss of ESI would boost OOP costs. A data brief by the Agency for Healthcare Research and Quality (AHRQ) indicates that out-of-pocket costs were $45 higher for people with private insurance of any kind when compared with the uninsured in 2011 (Machlin and Carper 2014). Inflating this by overall health care inflation since then leads to a 20 percent increase in these costs, or $54 per person. A brief by the Kaiser Family Foundation (KFF) finds that OOP costs were roughly 5 percent higher for those with nongroup insurance compared with those with ESI (DiJulio and Claxton 2010). Given this, taking the $54 dollar difference (inflated to 2017 dollars) is a conservative estimate of the change in OOP that will result from moving 7 million people from ESI to uninsured status.

Of course, the much more conservative part of this estimate is that purchasing any health care (and hence incurring any OOP costs at all) is endogenous to one's insurance status. Put simply, the OOP costs of uninsured people are kept low simply because they too often cannot afford to access any health care at all. We know, for example, that total health expenditures (whether paid by insurance or OOP) for those with private insurance were double those for the uninsured (Machlin and Carper 2014). So, the exposure to OOP costs is a radical understatement of how the move from ESI to uninsured status will limit people's ability to access and afford health care.

Nevertheless, if we just focus on OOP costs incurred by the AHCA's forced move of people from ESI to uninsured status, we calculate an increase of $460 million annually in higher out-of-pocket costs.

Conclusion

If the Republicans were sincere in their complaints about high deductibles and copays still faced by patients even after the passage of ACA, then their replacement plan would lower these costs. But this replacement plan, the AHCA, would not lower these OOP costs; instead it increases them enormously, to the tune of roughly $33 billion annually by 2026 ($16 billion in reduced cost-sharing subsidies plus $9 billion in degraded plan quality in nongroup markets plus $7 billion in increased OOP costs faced by former Medicaid recipients plus $460 million in additional out-of-pocket costs faced by those losing ESI).

Crucially, this implicit $33 billion tax is on top of the higher cost of premiums that the AHCA would create. Fiedler and Adler construct an apples-to-apples comparison of the cost of health insurance plans *of equivalent quality and for an equivalent population* in nongroup markets under the ACA and under the proposed AHCA. They find that the AHCA would boost premiums by 13 percent (Fiedler and Adler 2017). Because plan quality degrades and because older Americans would find it harder to get health insurance under the AHCA, the average *unadjusted* premium cost would fall 10 percent by 2026, but this is solely due to the younger mix of enrollees (which does not help the older Americans priced out of insurance coverage) and the degraded quality of insurance plans.

Finally, we should note that this large increase in OOP costs stemming from the Republican AHCA is not a quirk unique to this particular plan or evidence that they just

fouled up the execution of an otherwise well-intentioned strategy. Instead, increasing the costs that American patients face for obtaining health care is the entire Republican health care philosophy. They call it "consumer directed health care" sometimes (better.gop 2016), but what it means is that they think overall health care costs are best contained when American patients have "skin in the game" in terms of facing significant out-of-pocket costs when deciding to obtain health care. The theory is that by forcing patients to face high OOP costs, this will induce them to become wiser shoppers in health care markets.

We have noted previously that this "skin in the game" approach to designing health care policy and attempting to control overall health care cost growth is a flawed strategy (Gould 2013). It does indeed work to reduce costs, but it does so by inducing patients to cut back across-the-board on the care they receive, regardless of how effective or necessary this care is (Brot-Goldberg et al. 2015). In short, this approach is a shotgun blast to cost-control, rather than the surgical approach that is needed. Cost-control needs to be an exercise in maximizing the value for dollar as opposed to an exercise in arbitrary medical rationing.

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