Updated: Who Gains and Who Loses under the Better Care Reconciliation Act

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On July 11, 2017, we released our analysis of the distributional effects of the tax and health care benefit changes that would occur under the proposed Better Care Reconciliation Act (BCRA).[1] On July 13, the Senate leadership introduced a modified version of the bill.[2] Here, we update our previous analysis of the changes in taxes and federal health benefits across families grouped by income to take these recent bill changes into account. This analysis does not take include the revised bill's Title III provisions introduced by Senator Cruz; the bill text encloses those provisions in bold brackets, indicating that their final inclusion has not yet been decided. We will analyze the Title III provisions later.

As in our earlier analysis, we use the Urban-Brookings Tax Policy Center Microsimulation Model and the Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (HIPSM) to analyze the effects of the bill. Additional methodological detail can be found in that brief.

The July 13 version of the BCRA differs from the prior version mainly in the following ways:

- It would not eliminate the 3.8 percent net investment income tax or the 0.9 percent additional Medicare hospital insurance tax.

- It would introduce a new tax benefit, permitting those purchasing nongroup insurance coverage compatible with a Health Savings Account to pay premiums with pretax dollars.[3]

- It would allow people purchasing catastrophic insurance policies in the nongroup market to use a premium tax credit for which they are eligible.

■ It would increase the federal dollars allocated to the State Stability Fund, which can be used for several purposes, including reinsurance for high-cost cases in the nongroup market, cost-sharing assistance, and premium assistance. As in the prior version of the BCRA, state matching funds would be required to draw down the federal dollars in most years.

We find that even with the proposed changes, the BCRA's effects remain very regressive, although somewhat less regressive than the previous version, in large part because the new bill retains the 3.8 percent net investment income tax and the 0.9 percent additional Medicare hospital insurance tax. Taking both tax reductions and benefit reductions into account, the average high-income family would be better off, and the average low-income family would be significantly worse off, under the revised BCRA than under current law. The average family with less than $10,000 of income in 2026 would be $2,780 worse off, a net reduction of 67 percent of the family's income (figure 1 and table 1). The average family with more than $200,000 of income in 2026 would be $900 better off, a net increase of 0.2 percent of the family's income. Using a measure of family income as a percentage of the federal poverty level (FPL), families with incomes below 400 percent of FPL would experience net tax and benefit losses, and families with incomes above 400 percent of FPL would experience net gains under the revised BCRA (table 2). The greatest net gains would go to families with incomes above 600 percent of FPL.

FIGURE 1

Distribution of Change in Average Net Transfers (Benefits less Taxes) under the BCRA Compared to Current Law, 2026
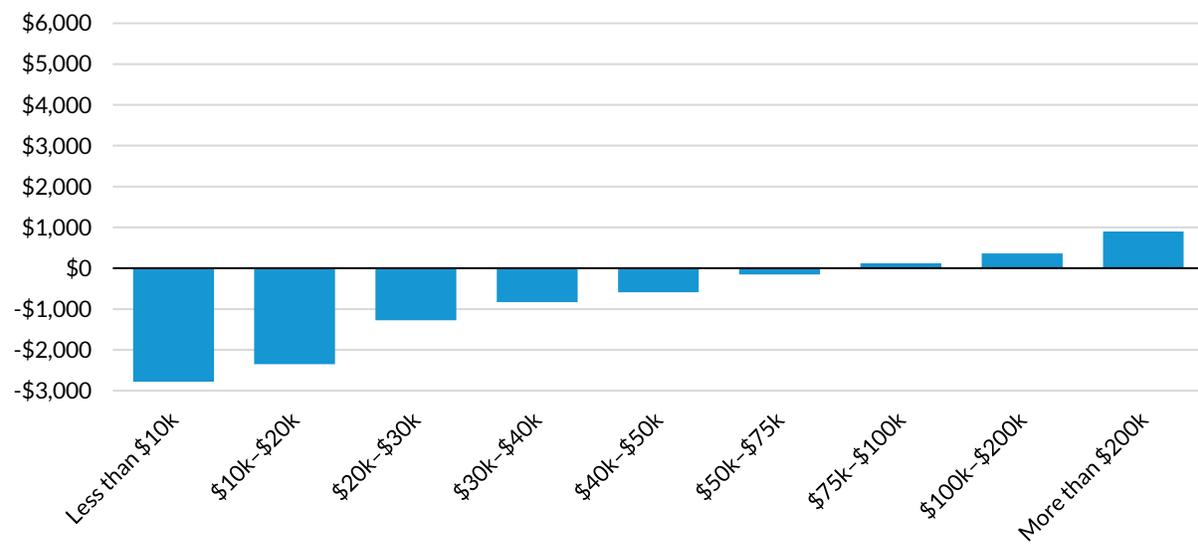
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Sources: Urban-Brookings Tax Policy Center Microsimulation Model (version 0217-1) and Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (2017).
Notes: Income is modified adjusted gross income (MAGI), defined as adjusted gross income plus nontaxable Social Security benefits and tax-exempt interest. Analysis includes both filing and nonfiling units but excludes dependents of other tax units. Tax units with negative MAGI are excluded from the bottom income class but are included in the totals. Analysis includes provisions from the discussion draft of the BCRA released by the Senate Budget Committee on June 22, 2017.

TABLE 1

Distribution of Change in Net Transfers (Benefits less Taxes) under the BCRA Compared to Current Law, 2026

Income[a]	Number of tax units[b] (thousands)	Share of all tax units (%)	Average net transfer change per tax unit ($)	Average net transfer change as percentage of income (%)
< $10,000	15,110	8.1	-2,780	-67.1
$10,000–$20,000	18,710	10.1	-2,350	-15.6
$20,000–$30,000	22,820	12.3	-1,280	-5.1
$30,000–$40,000	19,350	10.4	-830	-2.4
$40,000–$50,000	13,980	7.5	-590	-1.3
$50,000–$75,000	29,300	15.8	-150	-0.3
$75,000–$100,000	17,870	9.6	120	0.1
$100,000–$200,000	33,050	17.8	360	0.3
> $200,000	14,210	7.7	900	0.2
All	185,420	100.0	-630	-0.7

Sources: Urban-Brookings Tax Policy Center Microsimulation Model (version 0217-1) **URBAN** INSTITUTE
and Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (2017).

[a] Income is modified adjusted gross income (MAGI), defined as adjusted gross income plus nontaxable Social Security benefits and tax-exempt interest. Analysis includes both filing and nonfiling units but excludes dependents of other tax units. Tax units with negative MAGI are excluded from the bottom income class but are included in the totals.

[b] A tax unit is a person or a married couple who files a tax return or would file a tax return if their income were high enough, along with all dependents of that person or married couple. A tax unit differs from a family in certain situations.

TABLE 2

Distribution of Change in Net Transfers (Benefits less Taxes) under the BCRA Compared to Current Law, 2026

Income relative to FPL[a]	Number of tax units[b] (thousands)	Share of all tax units (%)	Average net transfer change per tax unit ($)	Average net transfer change as percentage of income (%)
< 50% of FPL	12,940	7.0	-2,690	-74.3
50–100% of FPL	17,570	9.5	-1,790	-11.8
100–138% of FPL	14,370	7.7	-2,720	-11.5
138–200% of FPL	22,870	12.3	-1,200	-3.7
200–300% of FPL	30,390	16.4	-340	-0.7
300–400% of FPL	22,960	12.4	-80	-0.1
400–500% of FPL	16,500	8.9	200	0.2
500–600% of FPL	13,030	7.0	280	0.3
> 600% of FPL	33,770	18.2	610	0.2
All	185,420	100.0	-630	-0.7

Sources: Urban-Brookings Tax Policy Center Microsimulation Model (version 0217-1) **URBAN** INSTITUTE
and Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (2017).

[a] Income is modified adjusted gross income (MAGI), defined as adjusted gross income plus nontaxable Social Security benefits and tax-exempt interest. Analysis includes both filing and nonfiling units but excludes dependents of other tax units. Tax units with negative MAGI are excluded from the bottom income class but are included in the totals.

[b] A tax unit is a person or a married couple who files a tax return or would file a tax return if their income were high enough, along with all dependents of that person or married couple. A tax unit differs from a family in certain situations.

Notes

[1] See Linda J. Blumberg, Matthew Buettgens, John Holahan, Gordon B. Mermin, and Philip Stallworth, "Who Gains and Who Loses under the Better Care Reconciliation Act" (Washington, DC: Urban Institute, 2017).

[2] Better Care Reconciliation Act of 2017, H.R. 1628, 115th Cong. (2017), https://www.budget.senate.gov/imo/media/doc/BetterCareJuly13.2017.pdf

[3] Individuals eligible for advanced premium tax credits using their credits to purchase an HSA compatible policy can only pay the portion of their premium that exceeds their percent of income cap using pre-tax dollars.

About the Authors

Linda J. Blumberg is a senior fellow in the Health Policy Center at the Urban Institute, having joined in 1992. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA)—in particular, providing technical assistance to states, tracking policy decisionmaking and implementation efforts at the state level, and interpreting and analyzing the implications of specific policies. She codirects a large multiyear project using qualitative and quantitative methods to monitor and evaluate ACA implementation in states and nationally. Examples of her research include several analyses of competition in nongroup Marketplaces, estimation of the implications of ACA repeal through the reconciliation process, strategies for improving the ACA, an array of studies on the implications of the *King v. Burwell* Supreme Court case, analysis of the remaining uninsured, and codirecting 22 state case studies of stakeholder perspectives on ACA implementation. She also led the quantitative analysis supporting the development of a "Roadmap to Universal Coverage" in Massachusetts, a project with her Urban colleagues that informed the 2006 comprehensive reforms in that state. She received her PhD in economics from the University of Michigan.

Matthew Buettgens is a senior research analyst in the Health Policy Center, where he is the mathematician leading the development of Urban's Health Insurance Policy Simulation Model (HIPSM). The model is currently being used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes a number of research papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments; small firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance coverage and the remaining uninsured; the effect of reform on employers; the

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John Holahan is an Institute fellow in the Health Policy Center, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth. He has developed proposals for health system reform, most recently in Massachusetts. He has examined the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA.

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