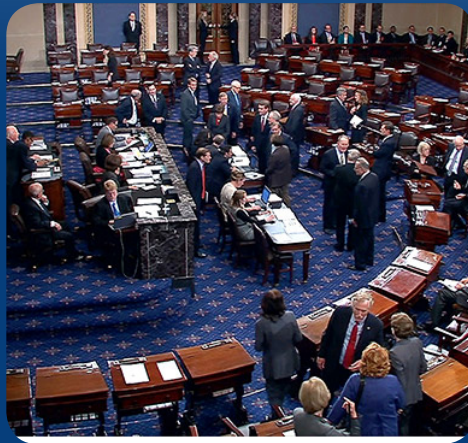


AMERICANS ON THE AMERICAN HEALTH CARE ACT



A National Survey of Voters

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INTRODUCTION

Since the Republican Party gained control of the White House as well as both Houses of Congress in the 2016 election, a primary focus for the Republican Party has been to repeal and replace the Affordable Care Act (ACA), also known as Obamacare. Initial efforts in the House proved more difficult than anticipated and the first bill proposed was pulled before the vote could occur, revealing the fragility of support even within the Republican caucus. Ultimately, though, on May 4, 2017 the House passed the American Healthcare Act (AHCA) with a party-line vote of 217 to 213.

The bill was forwarded to the Senate. The Republican leadership in the Senate has indicated that they plan to write their own version of the bill; however, many of the components being considered are similar to the basic components of the House bill.

Concern about public opinion toward the reforms being considered has been high. Existing polling on the AHCA has been fairly negative. This appears to be a key reason that the Senate Republican deliberations have been unusually nontransparent.

And yet very little is known about public opinion on the specific components of the AHCA, and how it compares to the public's views of the components of the ACA. Most polls have simply asked about views of the bill as a whole.

Earlier research has shown that such polls provide limited insight. While earlier polls that asked about the ACA per se often found divided responses, closely tracking partisan alignments, polls that explored the elements in the legislation found majorities in support of many of the key provisions. Thus, it appears that responses were driven primarily by partisan affiliations or views of President Obama--more than by the actual policy content.

In developing this survey, the objective was to go beyond partisan responses and to have respondents engage more directly with the policy issues. Thus, care was taken to avoid offering partisan triggers. The AHCA was simply described as a "proposed law" under consideration, as compared to "current law."

More significantly, the survey was conducted using the method of a policymaking simulation. The goal of a policymaking simulation is to put respondents into the shoes of a policymaker, to give them a short briefing on the policy options being proposed, to evaluate arguments for and against the proposed provisions of the law one at a time, and only then to ask respondents for their conclusions. This opens up the possibility of giving very specific input on the many components of the legislation, rather than just a general feeling about the legislation as a whole.

Design of the Survey Content

Besides studying the AHCA legislation itself, the development of the survey content entailed analyzing public statements by both proponents and opponents of the legislation. Assessments by the Congressional Budget Office were examined and incorporated into the survey itself.

A draft of the survey content was reviewed by both proponents and opponents of the legislation, to ensure that the briefings of the components of the legislation were accurate and fair and that the arguments for and against the legislation were the strongest ones being made in the discourse.



The survey began by introducing the legislation and presenting the CBO estimates of the proposed law's impact over a 10-year period in terms of the reduction in government spending on healthcare (\$993 billion), a reduction in various taxes (\$664 billion), a reduction in the budget deficit (\$119 billion) and an increase in the number of people without health insurance (23 million).

The first area explored was the difference between the current law and the proposed law in how they deal with low-income people. First, the four main areas of the current law were presented and evaluated. Then the five main areas of the proposed law were presented and evaluated. Only after completing this review were respondents asked to evaluate the AHCA's approach to low-income people as a whole. At that point arguments were presented and assessed, both in favor of the proposed law and in favor of preserving current law. Finally, respondents were asked whether they favored or opposed the proposed law's approach to low-income people.

Because the vast majority of the spending changes are included in the spending changes related to low-income people, the changes to the tax law were explored in this context, to highlight the tradeoffs entailed.

The survey then proceeded to explore other key provisions of the proposed law. In each case respondents received a short briefing, evaluated arguments in favor and against the provisions and then made a final recommendation. These included:

- Repealing the employer mandate
- Replacing the individual mandate with a renewal penalty
- Allowing higher premium rates for older insurees
- Allowing consideration of pre-existing conditions
- Repealing requirement for covering essential benefits
- Disallowing access to Planned Parenthood

Fielding of Survey

The survey was fielded by Nielsen-Scarborough with a probability-based representative sample of registered voters. The sample was provided by Nielsen-Scarborough from its larger sample, which is recruited by telephone and mail from a random sample of households. The survey itself was conducted online. The survey was fielded June 8th through June 13th, 2017.

Sample: 2,430 registered voters; Margin of Error: +/- 2%

Responses were subsequently weighted by age, income, gender, education, race and geographic region. Benchmarks for weights were obtained from the US Census' Current Populations Survey of Registered Voters. The sample was also weighted by partisan affiliation.



SUMMARY OF FINDINGS

Overall Assessment of AHCA

At the end of the survey, after evaluating all of the different aspects of the AHCA as compared to the ACA, two thirds opposed the AHCA. More than nine in ten Democrats and seven in ten independents were opposed. Just under two thirds of Republicans were in favor. Opposition ranged from six in ten in very red districts to eight in ten in very blue districts.

Healthcare for Low-Income Populations

The survey began with assessments of the ACA's plan for low-income populations. Majorities found acceptable its plan for Medicaid expansion, premium support, support for out of pocket expenses and its tax plan. Overall, six in ten found the ACA plan acceptable. Support was only slightly lower in very red districts overall and in relation to all but one of the components. All but one of the components was found acceptable to majorities of Republicans; overall half of Republicans also found it acceptable and two thirds found it at least tolerable. Among independents six in ten found it acceptable, as did three quarters of Democrats.

Respondents then evaluated the AHCA plan for low-income people. Majorities found unacceptable its general reduction in spending on low-income healthcare, its plan for repealing the expansion of Medicaid, its premium support plan, its plan for out of pocket expenses, and its repeal of the ACA taxes. Half or more in the very red districts found all of the specific components unacceptable.

Asked for their overall assessment, six in ten opposed the general AHCA plan for addressing low-income populations. Opposition ranged from modest majorities in very red districts, to three quarters in very blue districts. The AHCA plan was opposed by six in ten independents and nine in ten Democrats. Six in ten Republicans favored it.

Repealing Employer Mandate

Two thirds opposed the AHCA's repeal of the requirement that employers with more than 50 employees provide healthcare insurance. Opposition ranged from six in ten in very red districts to three in four in very blue districts. Six in ten independents opposed it, as did nine in ten Democrats. However, six in ten Republicans favored it.

Replacing the Individual Mandate with Renewal Penalty

The idea of replacing the individual mandate with a penalty upon renewal received the highest level of support of all the AHCA provisions, but still it was opposed by a clear majority, a modest majority of independents and eight in ten Democrats. Seven in ten Republicans favored it. In very red districts views were evenly divided, while in very blue districts two thirds were opposed.

Allowing Higher Premium Rates for Older Insurees

AHCA allows insurance companies to charge older individuals five times more than younger people--as compared to three times more under current law. This was the least popular provision, with eight in ten opposing it. This opposition was a striking bipartisan consensus, with two thirds of Republicans opposed as well as eight in ten in very red districts.

***Allowing Insurance Companies to Consider Pre-existing Conditions***

Allowing states to get waivers that would allow insurance companies to charge higher rates to individuals with pre-existing conditions was another AHCA provision that encountered overwhelming and bipartisan opposition. Eight in ten were opposed, as were six in ten Republicans. Three quarters were opposed in very red districts, as well as more than eight in ten in very blue districts.

Repealing of Requirement for Covering Essential Benefits

The AHCA has a provision that gives states the ability to get a waiver allowing insurance companies to offer plans that do not include certain benefits required under the ACA, thus enabling lower-cost plans. This provision was opposed by two thirds nationally, six in ten in very red districts and three quarters in very blue ones. It was also opposed by six in ten independents and eight in ten Democrats. A majority of Republicans, though, favored it.

Disallowing Access to Planned Parenthood

Two thirds opposed the AHCA provision not allowing government-funded health benefits to be used at Planned Parenthood clinics. Six in ten were opposed in very red districts, as compared to eight in ten in very blue districts. Among independents seven in ten were opposed, as were nine in ten Democrats. Nearly two thirds of Republicans were in favor.





FINDINGS

Overall Assessment of AHCA

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At the end of the survey, after evaluating all of the different provisions described above in the bulk of this report, respondents were shown a recap of the CBO's assessment of the consequences of the AHCA, saying that it would result in:

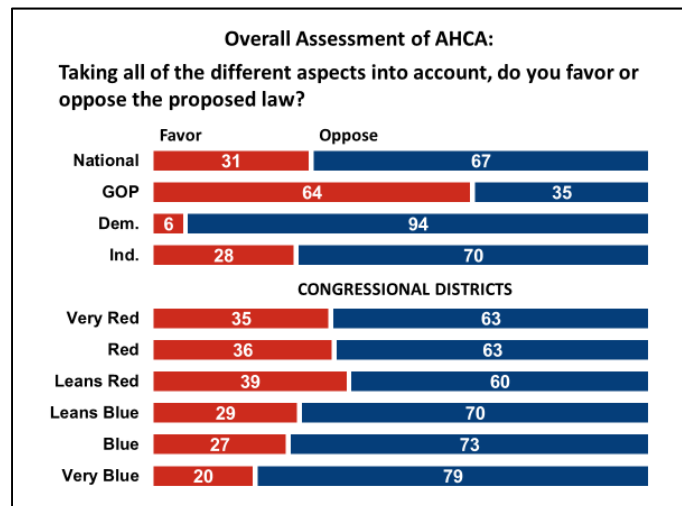
- A reduction in government spending on healthcare of \$993 billion
- A reduction of various taxes of \$664 billion
- A reduction in the budget deficit of \$119 billion
- An increase in the number of people without health insurance of 23 million

Respondents were also asked whether they wanted to go through a review of all the provisions previously considered—one in four elected to do so.

Finally, they were asked, “Taking all of the different aspects into account, do you favor or oppose the proposed law?” Two thirds (67%) opposed it, with 31% in favor.

Even in very red districts, over three in five opposed the AHCA (63%). In very blue districts, this was 79%.

Independents' opposition was higher with seven in ten (70%) opposed. Among Democrats, an overwhelming 94% were opposed. Sixty-four percent of Republicans favored it.



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The first topic that respondents were presented dealt with healthcare for low-income people. Respondents were told that “One of the biggest differences between current law and the proposed law is how they deal with health care for low-income people,” and then considered four major provisions of the ACA.

Assessing Current Law

Medicaid expansion was explained as a “cooperative program between the federal government and the states,” with variations in the coverage levels in different states. Expansions was described this way:

Under current law, states can now choose to be part of a program that provides Medicaid coverage to more people--individuals who make up to \$16,642 or a family of three who makes up to \$28,179. This is substantially higher than in the states that do not choose to be part of this program.

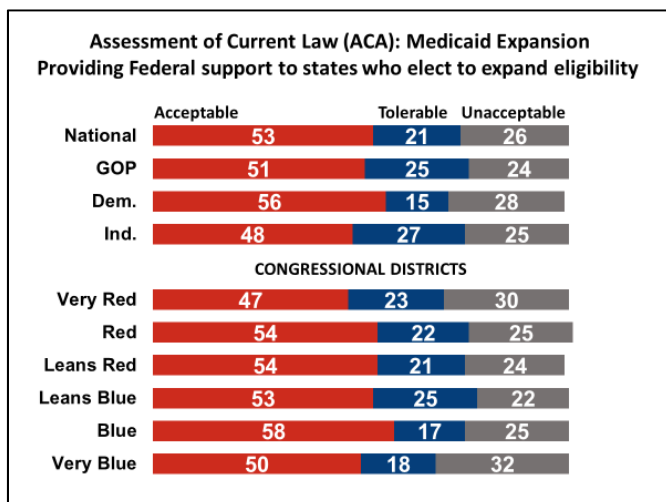
Under this program, the federal government currently pays about 95% of the cost, but in future years this amount goes down to 90%.

31 states have chosen to participate in the program. These states include 62% of the American population.

Asked how acceptable this was on a 0-to-10 scale--on which 0-4 is unacceptable, 5 just tolerable, and 6-10 acceptable--a modest majority (53%) called it acceptable. A larger 74% said it was at least tolerable, while 26% rated it as unacceptable. In the very red districts 47% found it acceptable (70% at least tolerable), while the highest level in the blue districts was 58% favorable.

There was strikingly little partisan variation nationally for such a controversial topic. Medicaid expansion was acceptable to 51% of Republicans (at least tolerable, 76%); 56% of Democrats (at least tolerable 71%); and 48% of independents (at least tolerable, 75%). The lower score among Democrats is presumably driven by Democrats who are not satisfied that the plan goes far enough—a substantial 14% rated it zero, higher than the 9% among Republicans.

Subsidies to help pay premiums were explained by using an example:





For people under the federal poverty line (individual \$12,060, couple with a child \$20,420), the subsidies fully cover their premiums, but as their incomes get above the poverty line, people are required to pay an increasing share of the cost of the premium.

Asked to evaluate this provision, 61% found it acceptable and an additional 17% found it tolerable, while 22% said it was unacceptable. Support across the levels of red and blue districts stayed within a range of 58% to 64%. Strikingly, again there was little national partisan variation with 62% of both Republicans and Democrats finding it acceptable--though independents were lower, with 56% finding this acceptable.

Help with out-of-pocket expenses was explained as “covering [low-income people’s] deductible and their co-payments for specific doctor visits.” People were given examples of the income range involved:

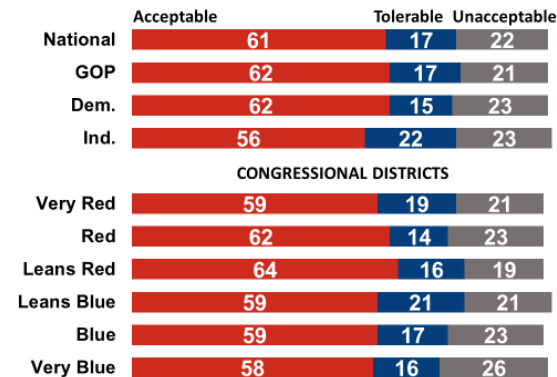
The amount the government pays decreases as the person’s income increases, stopping completely at \$30,150. An individual with an income of less than \$30,000 does not have to pay more than a total of \$2,250 for out-of-pocket expenses.

In rating this provision, 57% found it acceptable, and an additional 19% found it tolerable. Across all levels of blue and red districts, support ranged from 53% to 60% acceptable. Again, there was hardly any partisan variation (Republicans 57%, Democrats 60%), although independents were lower (51% acceptable).

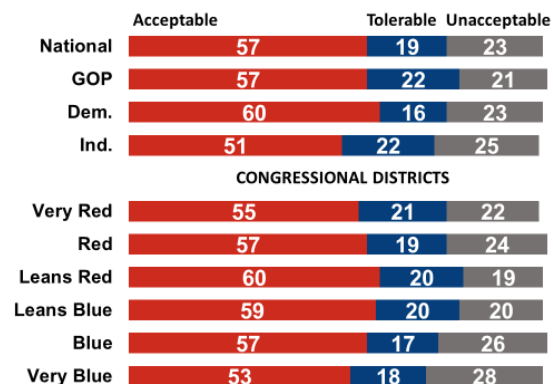
Tax provisions were the final part of current law presented to respondents. They were told that “This plan for low-income people generates most of the costs for current law as a whole,” and so “to offset the costs of current law several taxes were adopted.” The major ones were listed for them:

- An extra tax of 0.9% on income over \$200,000 for individuals (\$250,000 for couples), generating \$126 billion over 10 years
- An extra tax on investment income that can be as much as 3.8% for individuals with incomes over \$200,000 (\$250,000 for couples), generating \$172 billion over 10 years
- A tax on the largest for-profit health insurance companies, generating \$145 billion over 10 years

Assessment of Current Law (ACA): Premium Support
Providing Federal subsidies for premiums for low-income insureds



Assessment of Current Law (ACA): Out-of-Pocket Expenses Support
Providing Federal subsidies for out-of-pocket expenses for low-income insureds





- A reduction in the amount of medical expenses that can be deducted from income taxes, generating \$35 billion over 10 years
- An excise tax on medical devices, generating \$20 billion over 10 years

A 57% majority found these taxes acceptable. Even in the very red districts 55% found it acceptable.

Partisan differences were sharper, with 68% of Democrats finding the taxes acceptable, as compared to 45% of Republicans. However, 62% of Republicans found them at least tolerable. A 56% majority of independents found them acceptable.

The ACA plan for low-income people as a whole was then evaluated on the same scale. Three in five (62%) found it acceptable, with another 17% finding it tolerable. In very red districts 57% found it acceptable.

Three quarters of Democrats (74%) called this plan acceptable, as did 59% of independents. Most interestingly, Republicans did not give current law a particularly negative rating; indeed, half (49%) said it was acceptable, and 68% found it at least tolerable. Only 31% gave a rating of “unacceptable” for how the ACA handles the problem of insurance for low-income people.

Assessing the Proposed Law’s Plan

The survey then turned to evaluating the AHCA’s plan for low-income people.

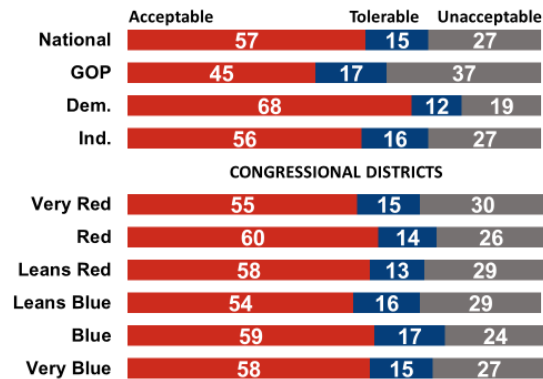
Its plan for **phasing out Medicaid expansion** was explained as follows:

First, current law’s plan to expand Medicaid would be phased out and ended in 2020. After that for all new Medicaid recipients, the Federal government would go back to paying about half of the cost. States would decide how high an income level they want to cover.

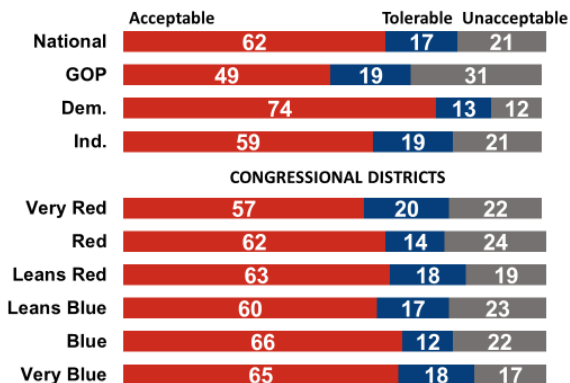
And respondents were told that “The CBO estimates that most states would let these levels go back down and thus 14 million fewer people would be on Medicaid.”

Respondents also learned that this would mean a substantial reduction in costs for the federal government.

Assessment of Current Law (ACA): Offsetting Taxes for Law as a Whole
Tax increases on upper incomes, investment income, large health insurance companies, medical devices



Assessment of Current Law (ACA):
Overall Assessment of Low-Income Program





Asked to evaluate this aspect of the proposed law on the same 0-to-10 scale, a modest majority of 53% found it unacceptable. In very red districts 50% found it unacceptable, with 36% calling it acceptable. In very blue districts two thirds found it unacceptable.

Republicans were much more positive than the whole sample, with 58% finding it acceptable. Independents were divided (49% unacceptable, 50% at least tolerable). Four in five Democrats (78%) called it unacceptable.

The AHCA plan for **gradually reducing what the Federal government pays for Medicaid** below current projections was presented this way:

[In future, what] the Federal government would need to pay per Medicaid recipient will go up for a number of reasons, for example because the average Medicaid recipient is getting older.

However, in the proposed law, the Federal government would put a limit on what it would pay, thus saving the Federal government money. States, then, can cover the difference, or reduce the number of people covered under Medicaid.

The CBO estimates that some states would cover the difference, while others would reduce the benefits people receive or the number of people covered.

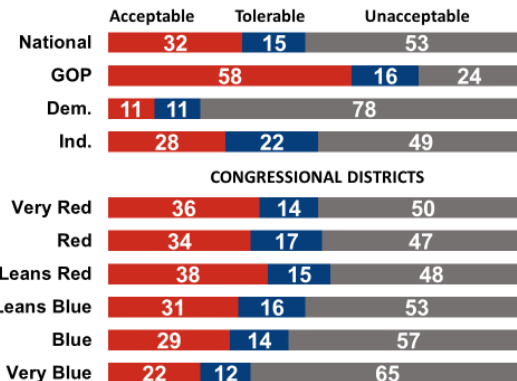
A 55% majority found this provision unacceptable. In very red districts 53% found it unacceptable, slightly more than 48% in red districts, while in very blue districts this ran as high as two-thirds.

Nationally four in five Democrats and 54% of independents thought it unacceptable, but 57% of Republicans found it acceptable.

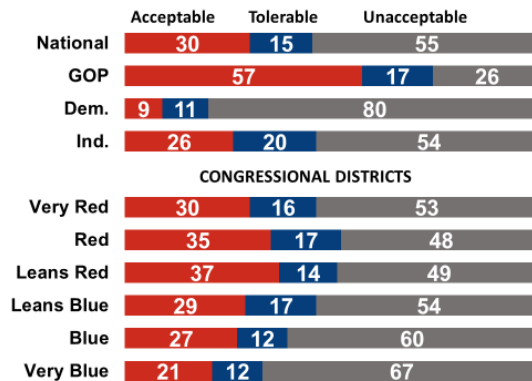
The AHCA's plan to **replace premium subsidies for individual insurance with a fixed tax credit**, varying only by age, was introduced by telling respondents the credit would be for those--

[with] an income below \$75,000 (\$150,000 for couples)... Young people would get \$2,000 per year and this would gradually rise to \$4,000 per year for people age 50-64. People with incomes over \$75,000 would get a credit too, but it would gradually decline as the income goes up.

**Assessment of Proposed Law (AHCA): Phasing out Medicaid Expansion
Ending current Medicaid expansion by 2020**



**Assessment of Proposed Law (AHCA):
Reducing Federal Spending on Medicaid
Setting a limit that is below current projections**





The effects, as estimated by CBO, were described this way:

- People with lower incomes would get less than they currently get, while people with moderate incomes would get more
- Though people in the 50-64 age group would get more than younger people, people in this age group with low income would get much less than they currently get

Asked to rate this part of the proposed law, 56% viewed it as unacceptable. In very red districts 54% found it unacceptable.

Fifty-six percent of independents and four in five Democrats found it unacceptable, but 55% or Republicans found it acceptable.

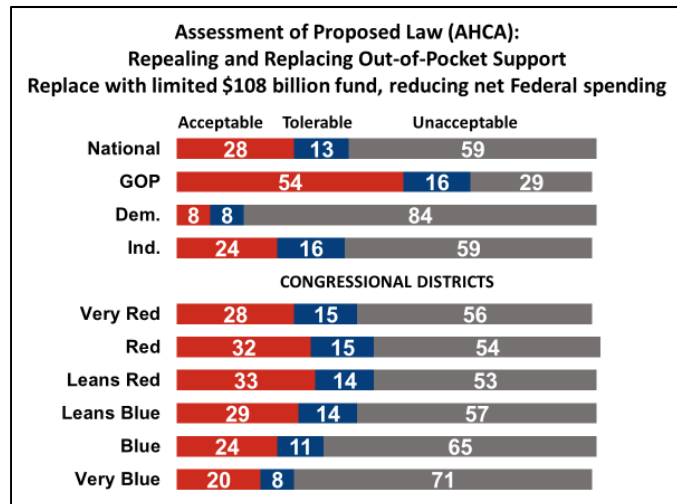
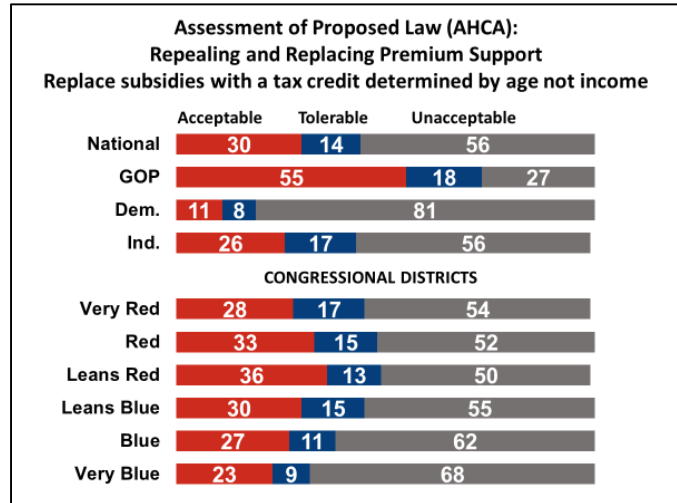
Respondents were told that the plan would **repeal subsidies for out-of-pocket expenses, and replace them with a \$108 billion fund for the states** to set up similar programs. Respondents were told that, according to the CBO:

...the \$108 billion would be significantly less than the increased out-of-pocket costs that low-income people would need to pay, and much of this \$108 billion would not be devoted to out-of-pocket expenses... For the government, the result would be a substantial reduction in costs...

Six in ten (59%) found this part of the proposal unacceptable. Across all categories of congressional districts majorities found this unacceptable, including 56% in very red districts.

Six in ten independents agreed, as did over four in five Democrats. A modest majority of Republicans (54%) did find it acceptable, and 70% found it at least tolerable.

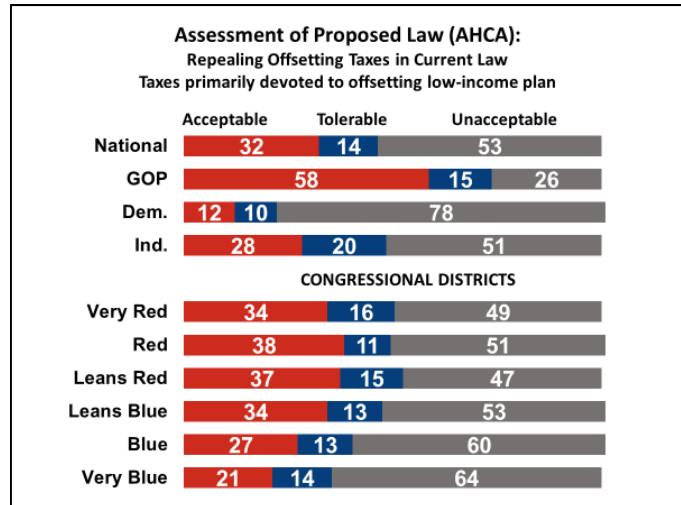
The plan for **repealing the taxes that are part of the ACA** was presented last. The list of the five major taxes was re-presented. Respondents also learned the proposed law would substantially increase “the amount of medical expenses that can be deducted, creating a tax cut—for those who itemize deductions—below the level that was in place before current law was established.”





The tax repeal aspect, presented alone, was also unacceptable to a majority (53%), though a modest one. Approximately half in all the red districts found it unacceptable; in very red districts 49% found it unacceptable while 50% found it at least tolerable (acceptable 34%).

A slight majority of independents found it unacceptable, as did four in five Democrats. Among Republicans a clear majority of 58% found it acceptable (75% at least tolerable).





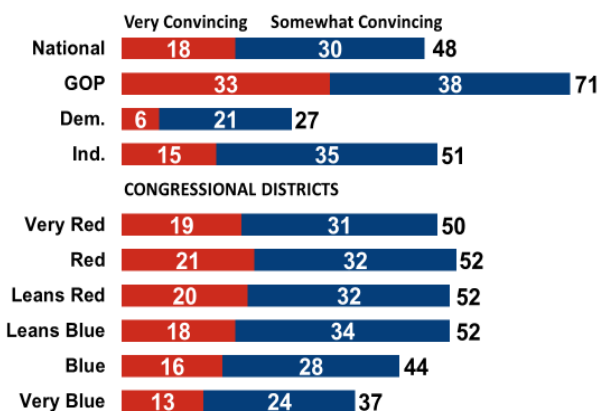
Evaluating Arguments

After respondents had considered the components of the current and proposed law in relation to the health needs of low-income people, they were asked to evaluate an argument favoring the approach under the proposed law, and another argument in favor of preserving the program under current law.

The argument in support of the AHCA summarized many points frequently made: that the able-bodied should be responsible, not dependent; that people with moderate incomes also deserve relief; that reducing taxes on upper incomes serves a vital economic purpose, stimulating investment and jobs; and that some devolution to the states is all to the good (see box). Respondents were then asked how convincing they found the argument.

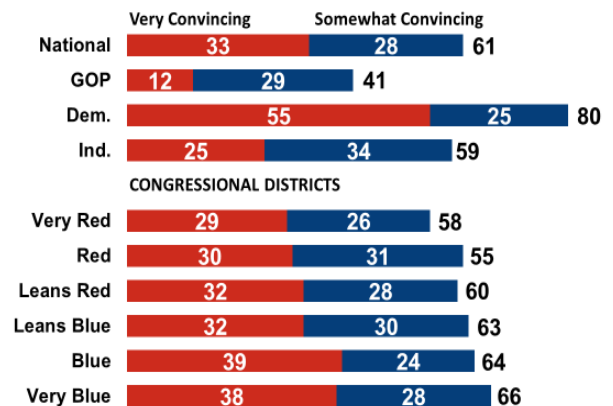
Argument in Favor of Program for Low-Income People Under Proposed Law (AHCA)

Current law has the government giving assistance to a lot of able-bodied people, many of whom are not all that poor, making them more dependent on the government. Much of the assistance goes so far that people hardly have to pay anything. The proposed law makes sure that people take more of the responsibility for their healthcare costs. Through tax credits, it also provides relief to moderate income people. Overall, it frees up funds that can be used to reduce taxes to higher income people so they can use that money for investments, stimulating the economy and creating jobs, including for many of these low-income people. Finally, reducing the federal government's role and letting the states take the lead is a good thing: states know the needs of their populations better, and when they are responsible, they will be more efficient in how they use funds.



Argument in Favor of Preserving Program for Low-Income People Under Current Law (ACA):

Current law has resulted in millions of low-income people and their children getting health insurance coverage for the first time, while still requiring them to pay a reasonable amount according to their income. With this help, these people are healthier, more productive, and more likely to move beyond needing help. Fewer people are going to emergency rooms, which reduces the burden on hospitals and society as a whole. The proposed law would reverse many of these gains. According to the CBO, 14 million low-income people would lose insurance coverage and millions more would not get needed medical services because they could no longer afford them--all so the wealthy and the health insurance companies can get a big tax break. There may be ways to make improvements to current law, but this proposed law goes way too far.





A modest majority of 52% found it unconvincing (very, 33%), while a little under half found it convincing (very, 18%). The reddest districts were divided; so were independents nationally. Seven in ten Republicans found the argument convincing, but only a quarter of Democrats did.

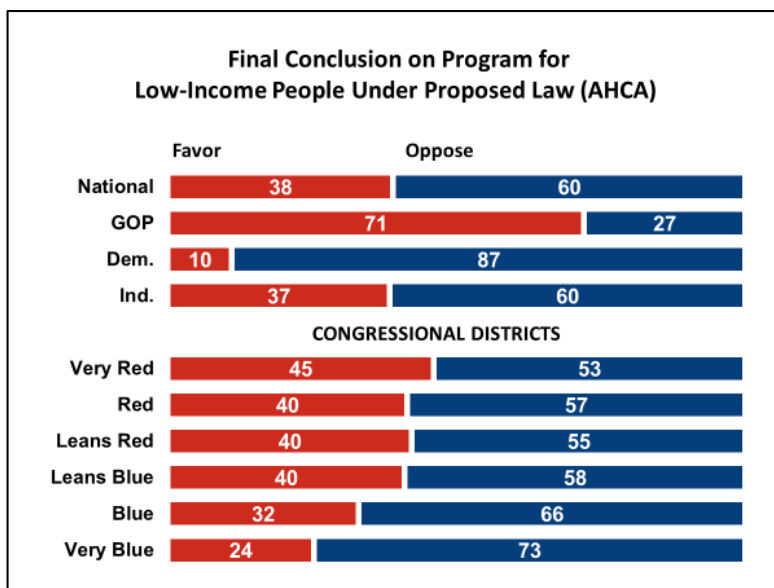
The argument in support of the ACA also included a host of points: that many have gained health insurance for the first time, increasing their potential for self-reliance; that hospital emergency rooms are less overburdened than before the law; and that a tax break for upper incomes is not worth the likely risk that the numbers of uninsured would rise again.

Three in five (61%) found this argument convincing and 38% unconvincing. In the reddest districts 55% found it convincing, and so did 58% of independents nationally. Four in five Democrats found it convincing, while 58% of Republicans did not.

Final Conclusion About AHCA's Plan for Low Income People

After assessing the arguments, respondents were presented a summary overview of the proposed law's plan for low income people and, finally, asked for their conclusion overall. Nationally 60% said they opposed the plan. In all categories of Congressional districts a majority opposed including 53% in the very red districts. In very blue districts 73% were opposed.

Like the sample as a whole, 60% of independents said they were opposed as were an overwhelming 88% of Democrats. However, 71% of Republicans said they were in favor; interestingly this was substantially higher than the numbers that found acceptable any of the component parts of the plan.





Repealing Employer Mandate

Two thirds opposed the AHCA's repeal of the requirement that employers with more than 50 employees provide healthcare insurance. Opposition ranged from six in ten in very red districts to three in four in very blue districts. Six in ten independents opposed it, as did nine in ten Democrats. However, six in ten Republicans favored it.

Respondents were told that in current law, all employers with over 50 full-time employees must provide health insurance that meets certain minimum standards or pay a penalty. The proposed law would repeal this requirement on employers.

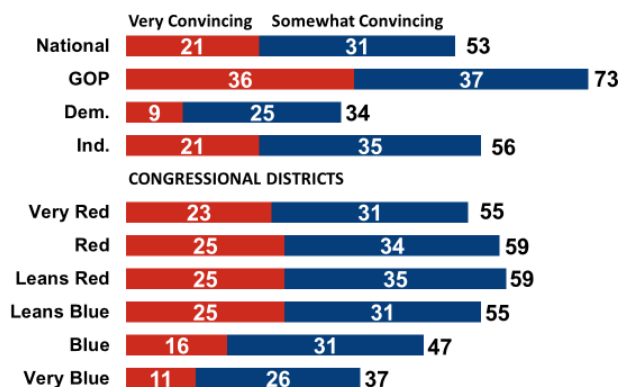
They also learned that the CBO estimates the change would result in fewer people with employer-provided coverage, and would also reduce federal revenues:

CBO estimates that if this requirement is removed, some employers would stop providing health insurance and, in combination with other parts of the new law, this would lead to three million fewer people having employer-provided coverage by 2026.

Another impact of the proposed law is that removing the penalties on employers would reduce federal revenues, estimated by the CBO to be \$171 billion, over the next 10 years.

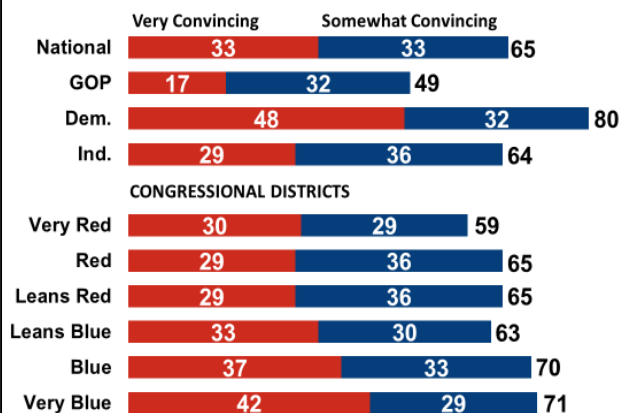
Argument in favor of the new proposal repealing the requirement that employers provide health insurance

There are numerous negative effects when Washington tells employers that they have to provide health insurance and dictates what the standards of that insurance should be. Some businesses may not be able to afford it and have to reduce wages or lay off workers. To avoid the requirement that they cover full-time employees, some employers may only hire part-time employees; this would hurt employees who prefer to work full-time, especially low-wage workers.



Argument in favor of preserving current law's requirement that employers provide health insurance

Removing the requirements on employers would lead many employers to stop providing health insurance, throwing many people off health insurance. The fact is that the large majority of Americans get their insurance through their employers and it is not right for some employers to refuse to do their part. It is also unfair that companies that do not provide insurance have an economic advantage over those who do.



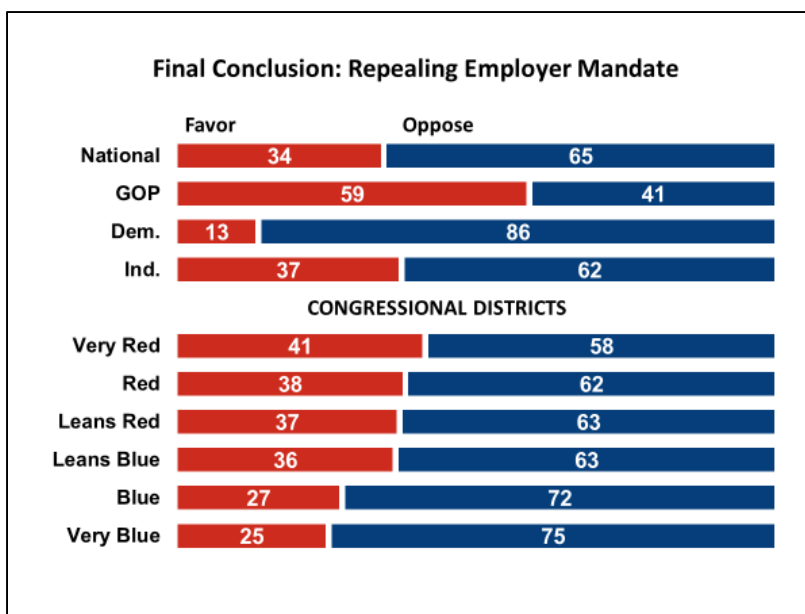


An argument favoring repeal asserted that the requirement distorts employers' behavior, leading them to lay off workers, reduce workers' hours, or seek only part-time workers. A modest majority (53%) found this convincing; in red districts this ran as high as 59%. Fifty-six percent of independents found it convincing, as did almost three in four Republicans. However, this was true of only one-third of Democrats.

The argument in favor of preserving the requirement did somewhat better. It made a normative case, saying "it is not right" for employers above a certain size not to offer health insurance and thus gain a competitive advantage. A larger, two-thirds majority (66%) found this convincing. In the reddest districts, 59% found it convincing. Among independents, this was 64% and among Democrats it was four-fifths. Republicans were divided.

Finally, asked whether they favored or opposed the proposed law's repeal of the mandate that employers provide insurance and that it meet a minimum standard, about two thirds (65%) opposed it, with 34% in favor. In the reddest districts 58% opposed repeal as compared to 75% in the bluest districts.

Sixty-two percent of independents were opposed, and Democrats were 86% opposed. Republicans favored repeal by about three in five.





Replacing the Individual Mandate with Renewal Penalty

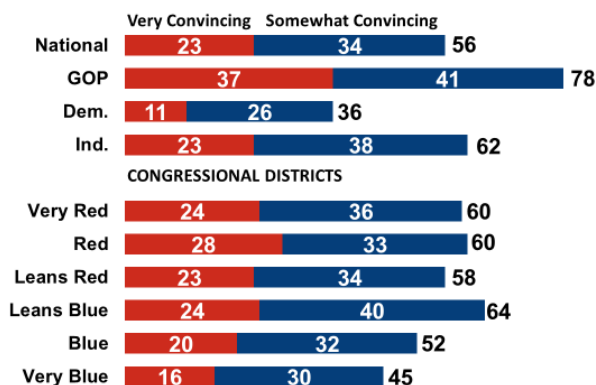
The idea of replacing the individual mandate with a penalty upon renewal received the highest level of support of all the AHCA provisions, but still it was opposed by a clear majority, a modest majority of independents and eight in ten Democrats. Seven in Republicans favored it. In very red districts views were evenly divided, while in very blue districts two thirds were opposed.

Past surveys have shown the individual mandate to be the least popular part of the ACA. The proposed law acknowledges the issue of keeping a large, healthy pool of insured people, and seeks to handle it a different way. But when asked to compare current law to the proposed approach, current law won out by a modest margin.

Respondents were first briefed on the problem of minimizing “free riders” on the health care system, and told current law requires all individuals to either have insurance or pay a penalty when they do their taxes. Then they were told about the proposed law’s approach:

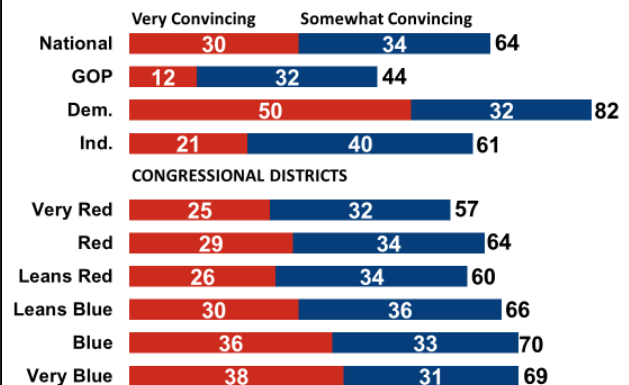
Argument in Favor of Replacing Individual Mandate with Renewal Penalty

People should have the right to decide for themselves whether or not they want to spend their money on health insurance. Current law forces people to buy insurance. That is an unjustified government intrusion into people’s lives. It is also not fair for people who are young and healthy who are being forced to effectively subsidize older and sicker people. Furthermore, it has not really worked—many young and healthy people would rather pay the penalty and stay out of the insurance pool. As a result, premiums have gone up. The proposed plan recognizes that people have to first decide they want health insurance. Once they are on a plan, they are likely to stay on it to avoid paying the surcharge. This rewards people for doing the right thing, rather than punishing them.



Argument in Favor of Preserving Individual Mandate

It’s easy to say it should be up to the individual if they get insurance, but when someone doesn’t have insurance, it can have a major negative impact on society. We require people to have insurance to drive a car, because others can get hurt. When people get addicted to drugs and don’t get treatment, the damage to society can be huge. When people without insurance get sick, they go to emergency rooms, which is very inefficient and imposes major costs on hospitals. The CBO study shows that just having a 30% surcharge won’t solve this problem and would result in millions more people without insurance. Furthermore, the surcharge would go to the insurance company, while the penalty of current law helps pay for the negative effects of the person not having health coverage.





The requirement...would be repealed and would be replaced by another means of ensuring that people have insurance...

- First, there would be a grace period of a year during which people could sign up for insurance, just like they can now
- After that year, if someone does not have insurance or stops having insurance for more than 63 days within the past year and then later decides to get insurance, the health insurance company would add a surcharge on their premiums by 30% for the first year

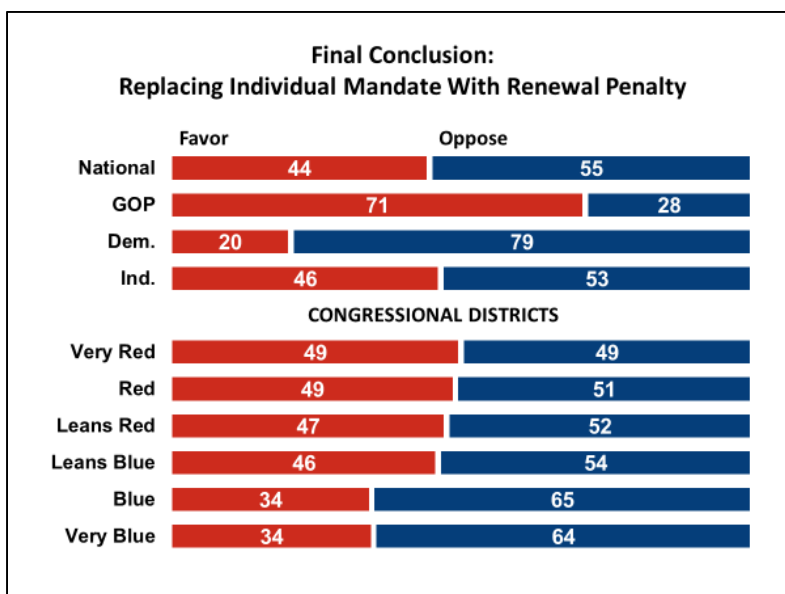
Finally, they were told of CBO's estimate of the effects of this approach. In the first-year grace period, about a million more people would get insurance to avoid the surcharge. Once the surcharge rule was in effect, it would drive up the number of those without insurance because they would avoid the surcharge. Ten years out, premiums would be up because fewer younger and healthier people would be part of the insurance pool.

When respondents evaluated arguments, the argument in favor of the proposed law was found convincing by a clear majority, though the argument against was found convincing by a larger majority. Among independents the arguments were equally convincing, though a modest majority ultimately opposed the provision.

The argument for the proposed law's provision focused on people's right to decide for themselves whether or not to buy insurance, and argued that the penalty has not worked well and the surcharge will work better. This argument did fairly well, with 56% finding it convincing, and six in ten in red districts. Only in very blue districts did the number finding it convincing fall below half. Sixty-two percent of independents found it convincing, as did four in five Republicans. Only 36% of Democrats, however, thought it convincing.

The argument for preserving current law's individual mandate pointed out that when bad things happen to people without insurance, the society as a whole loses—and also that the insurance company, not the healthcare system, would get the money from the 30% surcharge. Almost two thirds (64%) found this argument convincing, as did 57% in the reddest districts. Three in five independents said it was convincing, as did four in five Democrats. A majority of Republicans found it unconvincing (56%).

When asked their position on this proposed change, 55% were opposed, with 44% in favor. The reddest districts were divided, while in blue districts two thirds were opposed. Among independents, 53% were opposed, as were four in five Democrats. Seventy-one percent of Republicans favored the change.





Allowing Higher Premium Rates for Older Individuals

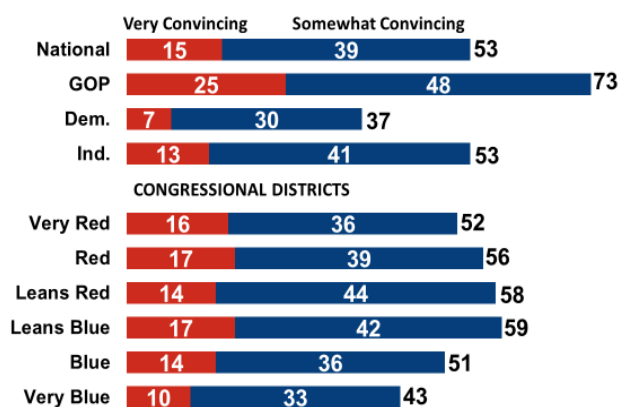
AHCA allows insurance companies to charge older individuals five times more than younger people--as compared to three times more under current law. This was the least popular provision, with eight in ten opposing it. This opposition was a striking bipartisan consensus, with two thirds of Republicans opposed as well as eight in ten in very red districts.

Respondents were first told the rationale for insurance companies charging older people more—which is a feature of both current law and proposed law:

As you may know, older people tend to use more health services than young people. Therefore, insurance companies charge older people higher insurance rates--specifically people aged 50-64 who are not yet on Medicare. Before current law went into effect, insurance companies generally charged about five times more for older people than for younger people.

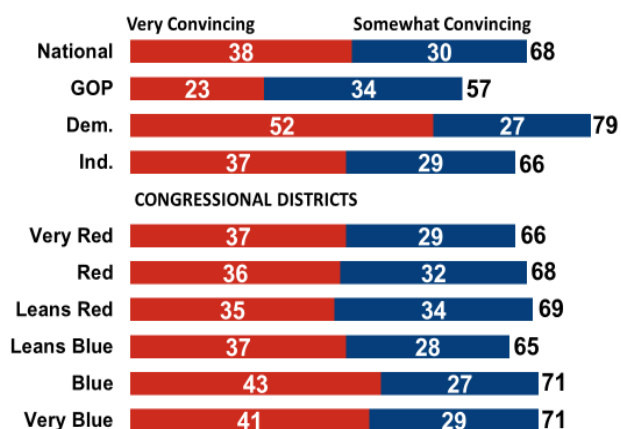
Argument in Favor of Allowing Higher Premiums for Older People

One of the biggest problems with our health insurance system today is that young people are not buying insurance. This drives up premiums, because it means that there are not enough younger, healthy people to offset the cost of providing medical services to older, less healthy people. It is also not fair to younger people, many of whom are just getting started in their careers, because currently they are paying more than it really costs to cover them. Letting insurance premiums more closely reflect the real costs of providing healthcare would both ensure that more young people get coverage, and that overall average premiums go down.



Argument in Favor of Preserving Current Limits on Higher Premiums for Older People

This plan would increase health care premiums for 50-64 year-olds while lowering them for young people. This is a bad deal for society as a whole. More importantly, it is very unfair to older Americans. In the years between 50 and 64, health risks grow steeply. We know that many of these people would not be able to afford the higher premiums and be left without care when they need it the most, putting them at serious risk of illness and even dying from a preventable cause. We need to remember that we will all grow old someday, and it is not right to try to help one age group at the expense of another.





Respondents learned that currently, insurance companies are not allowed to charge older people more than three times more than younger people, while the proposed law would raise this limit to five times more. They were told that CBO has estimated the most likely effects to be to:

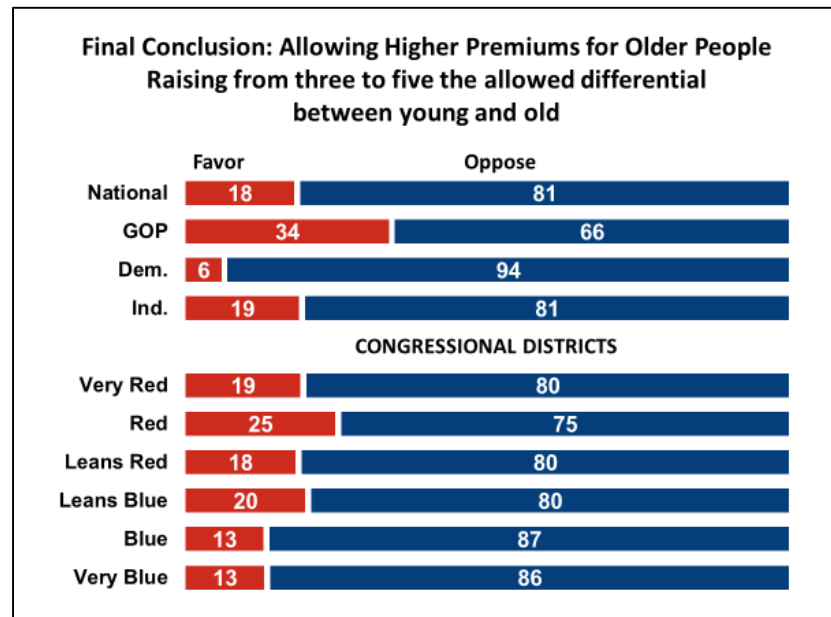
- Reduce the number of insured older people, as their premiums would be higher
- Increase the number of insured younger people, as their premiums would be lower
- Leave the average premium cost ten years from now around 10% lower than it would otherwise be

Interestingly, though this provision did not ultimately prove to be popular the argument in favor did reasonably well. The argument pointed out that not enough younger people choose to buy insurance, and claimed this problem could be fixed by letting premiums reflect more closely the real costs of providing healthcare to the young and the old respectively. This was convincing to a modest majority of 53%, with 46% disagreeing; the reddest districts were identical to this, and so were independents. Among Republicans, 73% found it convincing, but only one third of Democrats did.

The argument for preserving current law described the proposal as unfair because of the growth in health risks for people between 50 and 64, and made a moral point that generations should not be played off against each other. This argument did quite well, including with Republicans. Sixty-eight percent found it convincing, including 66% in the reddest districts and the same number among independents. Fifty-seven percent of Republicans and four in five Democrats found it convincing as well. Interestingly, the argument was found convincing by a smaller majority than the one that ultimately opposed the provision, suggesting the argument may not have fully captured some key reasons respondents opposed allowing a five-to-one ratio between young and old.

A very large bipartisan consensus opposed the proposal to allow insurance companies to charge older people as much as five times more than younger people. Four in five overall (81%) opposed it, as did 80% in even the reddest districts—only slightly less than the 86% in the bluest districts.

This was only one of two provisions opposed by a majority of Republicans and it was opposed by a hefty 66% of them, as well as 94% of Democrats and 81% of independents.





Allowing Insurance Companies to Consider Pre-existing Conditions

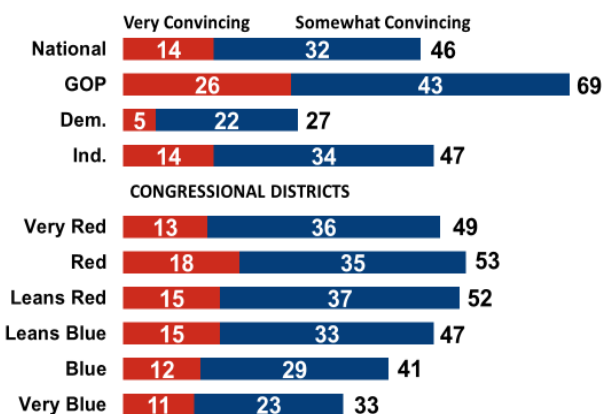
Allowing states to get waivers that would allow insurance companies to charge higher rates to individuals with pre-existing conditions was another AHCA provision that encountered overwhelming and bipartisan opposition. Eight in ten were opposed, as were six in ten Republicans. Three quarters were opposed in very red districts, as well as more than eight in ten in very blue districts.

Respondents were reminded that under current law, insurance companies cannot decline to cover someone with a pre-existing health condition or to charge them a higher premium. They were told:

The proposed law gives states the option to get a waiver that would let insurance companies refuse to provide insurance benefits for specific pre-existing conditions, or for conditions a person is more likely to get based on family history--or to charge a higher premium for benefits covering those conditions.

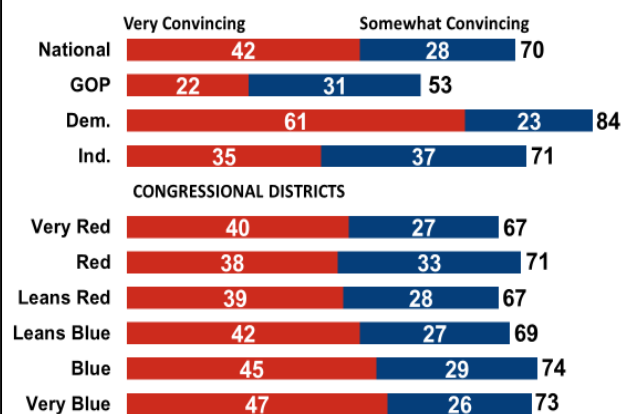
Argument in Favor of Allowing Insurance Companies to Consider Pre-existing Conditions

The proposed law lessens the power of the federal government to dictate how insurance should be and lets states develop their own guidelines based on what is best for that state. Unlike the federal guidelines, it allows states to give people the freedom to buy insurance policies that reflect their health conditions. It's not really fair to require that everybody pay the same price for insurance as people in poor health or with high-risk family backgrounds. Many health conditions are a function of how healthy one's lifestyle is, including how one eats or whether one exercises. The actual cost to the insurance company of providing insurance to people with healthy lifestyles is much lower. People should have the freedom to only pay the premiums that reflect the risk their insurance company takes on by insuring them personally.



Argument in Favor of Current Prohibition on Insurance Companies Considering Pre-Existing Conditions

Most health conditions are not a function of lifestyle, or are something you can control. Genetics play a very big role, as well as environmental pollution. It is not your fault if you have a chronic condition as a result of someone running you down. It is simply not fair to require someone to pay higher insurance rates because they have a greater history of a certain disease, or because their ancestors or race have a greater tendency to get a certain disease. By allowing companies to charge these high prices, some people would not be able to afford coverage and end up living miserable lives or even dying. It is better for society if everybody is treated equally. People should not be discriminated against based on their health and genetic background. The whole idea of insurance is to share risk, not to disadvantage some people more than others.





They then learned about the CBO's estimate of the outcome should this provision take effect:

- Some people would not be able to get insurance coverage for certain specific conditions
- Other people would be charged higher premiums, and some of these people—who would not be able to afford those higher premiums—would lose their insurance coverage.

They also learned that in compensation, the proposed law would dedicate funds to help states set up high-risk pools for such people—but that CBO estimated the amount set aside would be insufficient and some people would wind up without coverage. However, premiums would be lower for the majority of people with lower health risks, and some of these would get insurance who would not have done so otherwise.

The argument supporting the proposal asserted that “it’s not really fair to require that everybody pay the same price for insurance,” and that “people should have the freedom to only pay the premiums that reflect the risk” they actually pose to the insurance plan that enrolls them.

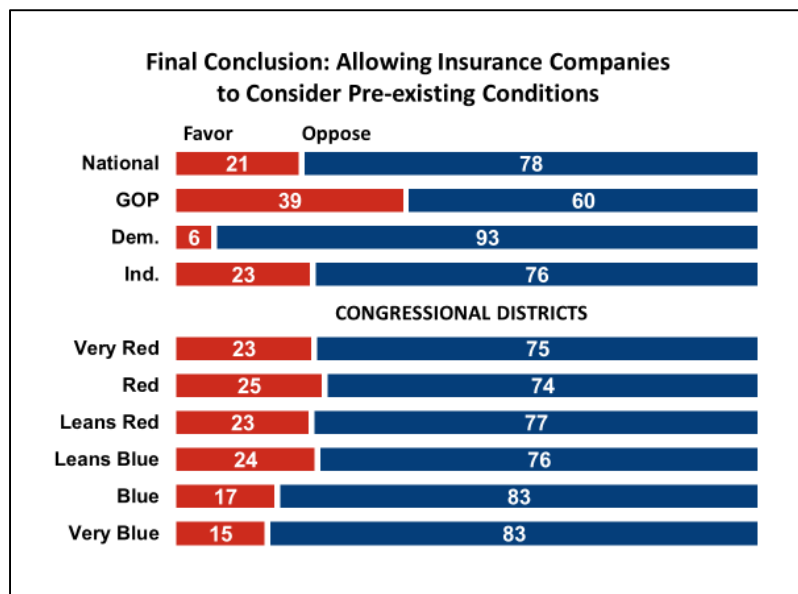
An unusually low 46% found this argument convincing while 53% found it unconvincing. Even in the reddest districts only half found it convincing. Just under half of independents and a quarter of Democrats found it convincing. However, seven in ten Republicans found it convincing, an interestingly high level given how few ultimately endorsed the idea.

The argument for preserving current law pointed out that most pre-existing conditions come from factors outside an individual’s control and said that “people should not be discriminated against based on their health.” Seven in ten found this argument convincing overall. Two thirds in the reddest districts said it was convincing, as did 53% of Republicans. Seven in ten independents and 84% of Democrats concurred.

factors outside an individual’s control and said that “people should not be discriminated against based on their health.” Seven in ten found this argument convincing overall, two thirds in the reddest districts said it was convincing, as did 53% of Republicans. Seven in ten independents and ad 84% of Democrats concurred.

In conclusion, a large bipartisan consensus rejected state waivers on pre-existing conditions. This was opposed by 78% nationally, and 75% in very red districts as well as 83% in very blue districts.

Interestingly, for Republicans, though the argument in favor did better than the argument against, 60% opposed the proposal--as did 76% among independents and 93% among Democrats.



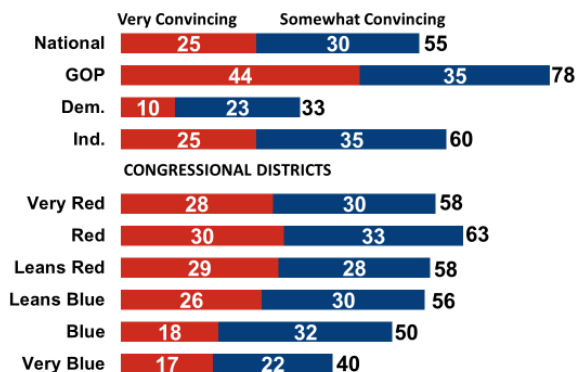


Repeal of Requirement for Covering Essential Benefits

The AHCA has a provision that gives states the ability to get a waiver allowing insurance companies to offer plans that do not include certain benefits required under the ACA, thus enabling lower-cost plans. This provision was opposed by two thirds nationally, six in ten in very red districts and three quarters in very blue ones. It was also opposed by six in ten independents and eight in ten Democrats. A majority of Republicans, though, favored it.

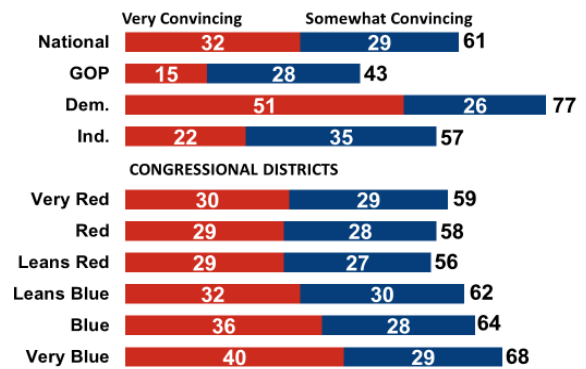
Argument in Favor of Allowing Insurance Plans That Do Not Cover “Essential Benefits”

Demanding that all insurance plans include certain benefits might sound reasonable and even helpful. But in fact, it is interfering with the people’s freedom to have the insurance that fits what they feel they need. Remember, more coverage means higher prices. So requiring these benefits means people are being forced to spend money against their will. People should have the right to decide if they want coverage for psychotherapy. For example, people should not be required to have benefits they are clearly not going to need. For example, men should not be required to have plans that cover pregnancy. Some people may prefer to only have catastrophic coverage for emergencies. People should have the freedom to get the kind of policy that they choose.



Argument in Favor of Current Requirement for Coverage of “Essential Benefits”

If the proposed law goes forward, insurance companies would use their lobbyists in state capitals to get waivers so that they do not have to cover important services. People may not even be aware those services are being cut, and employees would not be in a position to do anything about it when their company’s plan starts cutting corners to save money. People would not anticipate getting addicted to opioids; so if it happens, they may not be able to get the treatment they need, creating a real problem for society as well as for that person. The idea that people should be able to have individualized plans that exclude any service they might not need undermines the idea that insurance is about sharing risks. It is like saying that older people should not have to pay taxes for schools because they do not expect to have any more children.



Respondents were told that “Another central issue is whether certain benefits should be required in all health insurance plans, or if people should be able to get insurance with fewer benefits.” They were shown the list of ten essential benefits that under current law are required in all insurance plans:

- a. Outpatient services
- b. Emergency services



- c. Hospitalization (surgery and overnight stays)
- d. Pregnancy, maternity and newborn care
- e. Mental health and substance abuse treatment, including psychotherapy
- f. Prescription drugs
- g. Rehabilitative services to help people with injuries, disabilities or chronic conditions
- h. Laboratory services
- i. Preventive services, including immunizations and screening, as well as chronic disease management
- j. Pediatric services, including dental and vision care

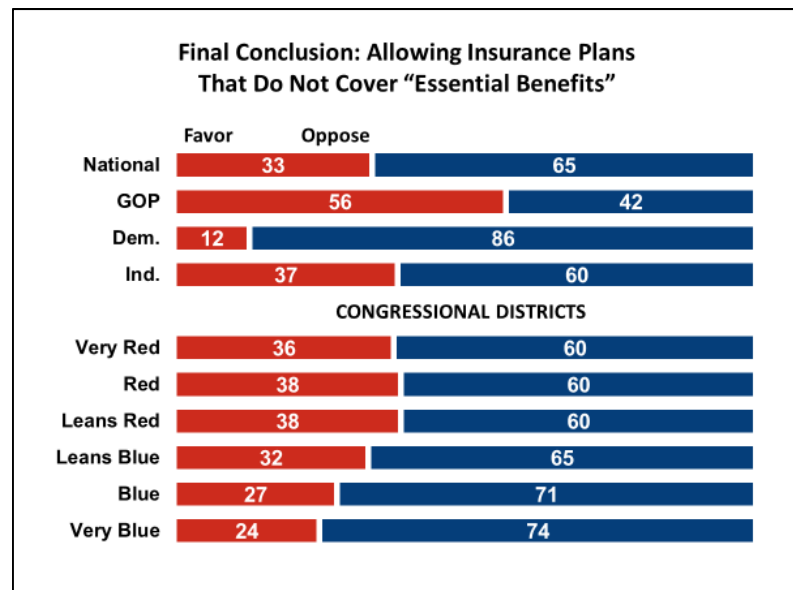
Respondents were told that the proposed law gives states the option of waiving some or all of the required benefits, so that insurance companies can offer policies that do not include them. It also gives all companies the right to offer health insurance plans to their employees that do not include some required benefits, provided that the requirement for that benefit has been waived in some state—even if it has not been waived in their own state.

In the argument for the proposal, respondents were reminded that “more coverage means higher prices” and told that “people should not be required to have benefits they are clearly not going to need.” This argument did rather well, with 55% finding it convincing—ranging as high as 63% among red districts. Six in ten independents found it convincing, and so did four in five Republicans. However, only a third of Democrats found it convincing.

The argument for preserving current law raised the possibility that insurance lobbyists in state capitals would get waivers to drop benefits before consumers were aware what was happening, and that this process would rapidly bleed over to employer insurance. This argument did slightly better than the pro argument, with about three in five finding it convincing, including in the reddest districts. Fifty-seven percent of independents found it convincing (Democrats: 77%). A majority of Republicans, though, found it unconvincing (56%).

Finally, respondents were shown the list again and asked whether they favored allowing states to waive the requirements to cover any or all of these benefits, so that health insurance companies can decline to cover these benefits and individuals can buy plans without these benefits.

About two in three (65%) opposed the proposal. Opposition was three in five in the reddest districts and among independents. Democrats opposed it by 86%. Fifty-six percent of Republicans favored it, while 42% were opposed.





Access to Planned Parenthood

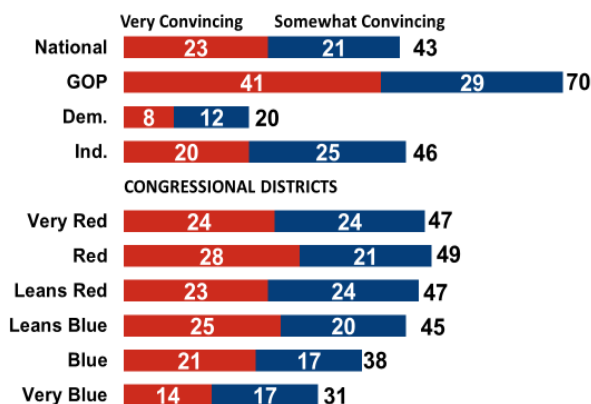
Two thirds opposed the AHCA provision not allowing government-funded health benefits to be used at Planned Parenthood clinics. Six in ten were opposed in very red districts, as compared to eight in ten in very blue districts. Among independents seven in ten were opposed, as were nine in ten Democrats. Nearly two thirds of Republicans were in favor.

The last specific provision of the proposed law considered by respondents was the barring of Planned Parenthood services for people using government-funded health programs. Respondents were told:

Planned Parenthood is controversial because one of their services is providing abortions--which makes up about 3% of all Planned Parenthood's services. These abortion services are not covered by Medicaid, since using federal funds for abortions is prohibited by law. However, it has been pointed out that some of the funds that Planned Parenthood receives for providing Medicaid services also help Planned Parenthood operate and stay open.

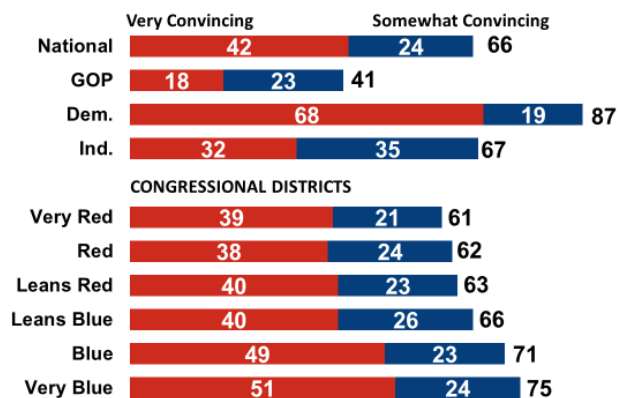
Argument in Favor of Disallowing access to Planned Parenthood

For moral reasons, the Federal government should not be involved with organizations that provide abortions like Planned Parenthood. Even if the federal money does not go directly to paying for providing abortions, some of that money goes to overhead and still helps Planned Parenthood continue to operate. Other health centers can provide the various non-abortion services that Planned Parenthood currently provides.



Argument in Favor of Allowing Access to Planned Parenthood

Women should be free to get permitted medical services where they choose, without the government discriminating against Planned Parenthood. In some low-income and rural areas, it is the only provider available and excluding it would hurt the health of women there. The CBO has also determined that if they cannot use Planned Parenthood, many women would not get family planning services and there would be many unplanned or unwanted pregnancies. This would create many costs for society and for Medicaid and can lead to more abortions that could have been prevented.



They then learned about the CBO's estimate of what would happen if the proposed law's rule against Medicaid patients receiving permitted services from Planned Parenthood went into effect:

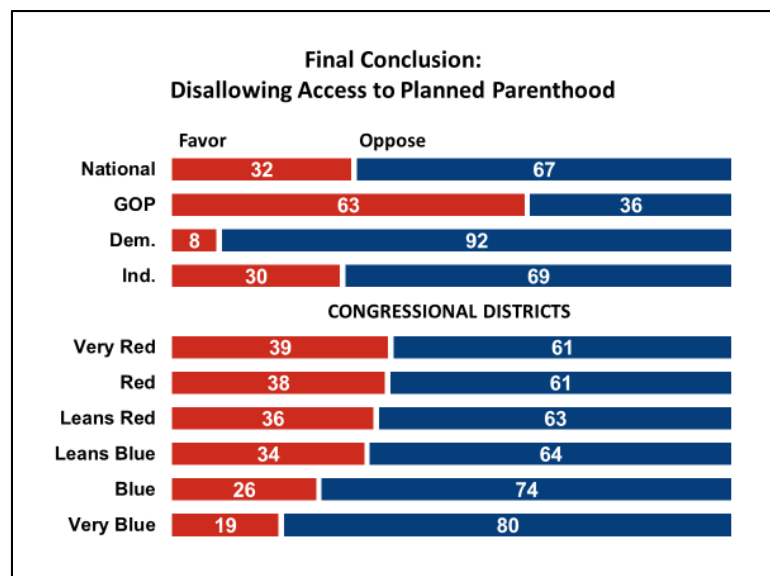
...because [Planned Parenthood] is the only provider of its services in some areas... 15 percent of Medicaid recipients would lose access to those services... [Thus] more women on Medicaid would have unwanted pregnancies, [which] would create an increased cost for Medicaid, plus the subsequent costs of their children who would also be covered by Medicaid.

The argument in favor of not allowing permitted services from Planned Parenthood insisted that for moral reasons, the federal government should not be involved with abortion providers even if federal money does not go directly to abortions. This argument did poorly, with only 43% finding it convincing and 56% calling it unconvincing. In the reddest districts 52% thought it unconvincing, and independents nationally were similar. Seven in ten Republicans found it convincing, while four in five Democrats did not.



In the argument for allowing Medicaid patients to continue to get coverage for permitted services from Planned Parenthood, it was described as the only provider available in some low-income and rural areas, saying "excluding it would hurt the health of women there," and that this could lead to unwanted pregnancies and even to more abortions. Two in three found this convincing, along with three in five in the reddest districts. Sixty-seven percent of independents found it convincing (Democrats, 87%), but it was unconvincing to three in five Republicans.

Nationally, 67% opposed excluding Planned Parenthood, including three in five in the reddest districts as well as eight in ten in the bluest ones. Seven in ten independents and nine in ten Democrats opposed it. However, among Republicans support exceeded three in five (63%).





Voice Of the People is a non-partisan organization that seeks to re-anchor our democracy in its founding principles by giving ‘We the People’ a greater role in government. VOP furthers the use of innovative methods and technology to give the American people a more effective voice in the policymaking process.

VOP is working to urge Congress to take these new methods to scale so that Members of Congress have a large, scientifically-selected, representative sample of their constituents—called a Citizen Cabinet—to be consulted on current issues and providing a voice that accurately reflects the values and priorities of their district or state.



PROGRAM FOR PUBLIC CONSULTATION

SCHOOL OF PUBLIC POLICY, UNIVERSITY OF MARYLAND

The **Program for Public Consultation** seeks to improve democratic governance by consulting the citizenry on key public policy issues governments face. It has developed innovative survey methods that simulate the process that policymakers go through—getting a briefing, hearing arguments, dealing with tradeoffs—before coming to their conclusion. It also uses surveys to help find common ground between conflicting parties. The Program for Public Consultation is part of the School of Public Policy at the University of Maryland.

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