

EXECUTIVE SUMMARY

The Impact of the 2009 America's Affordable Health Choices Act

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This work was completed independently for public dissemination. It was completed without funding or governance from any existing provider, payer or manufacturer. A more detailed and / or customized analysis is available upon request and circumstance.



2009 Affordable Health Choices Act

*Independent Assessment by HSI Network LLC
For Public Dissemination*

Summary Snapshot

The House of Representatives have passed the 2009 Affordable Health Choices Act in three subcommittees as of the August 2009 recess. The legislation provided adequate information to suggest what the impact would be of the legislation using the ARCOLA™ simulation model. This proposed bill would include an individual mandate as well as a pay or play provision. In addition, it would include a means-tested subsidy with premium supports available for those up to 400% of the federal poverty level. Public health insurance options would have three tiers: Basic, Enhanced and Premium; these are proposed in a structure similar to that of the Massachusetts Connector, and facilitated through a Health Insurance Exchange. These public plan options would contain costs by reimbursing providers up to 5% above current Medicare reimbursement rates. There is no mention of removing the tax exclusion associated with employer sponsored health insurance. There are limited changes to Medicare and Medicaid, including more robust fraud prevention, as well as modification of physician reimbursement in Medicare and the introduction of a Medicare medical home financing provision. These provisions could produce significant savings if fraud control programs were aggressively engaged. Below, we summarize the impact of the proposed plan in terms of the reduction in uninsured, the one year cost, as well as the ten year cost of the plan in 2010 dollars.

House Democrats Tri-Committee, 2009 Calibrated to CBO (7/14) Assumptions

- ❑ Uninsurance is reduced by **81%** to cover approximately **39.3 million people**
 - ❑ Subsidy - Tax Recovery = Net cost:
 - \$248.0 billion subsidy to the insured market
 - \$65.6 billion subsidy to group market
 - Net cost: **\$313.7 billion** (annual)
 - Net cost: **\$2.039 trillion** (10 year 2010-19, 2013 start)
 - ❑ Private market crowd out: **~9.6 million**
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The underlying simulation model used is ARCOLA™, a proprietary version of a health reform coverage and cost assessment analytic engine. A peer-reviewed presentation of the core model structure is summarized in the journal Health Affairs¹ and a longer version is available as a DHHS report at www.ehealthplan.org

Scoring Components

Major policy components considering for scoring:

- Employers would have to offer health insurance or pay a tax not as yet specified
- Individuals would have to be covered by a qualified plan or pay a tax
- Medicaid for everyone up to 133% of poverty level
- Sliding scale subsidy from 133% to 400% of poverty level
- The government would define a qualified plan with 3 levels of coverage: basic, enhanced, and premium. We assume the subsidy would be priced at the basic level of benefit design.
- All plans must use modified community rating: premiums can vary only by geographic region (to be defined), family structure, actuarial value of benefits, and age (maximum 2:1 range).
- Public plan that pays Medicare rates +5%
- Small-employer tax subsidy

Revisions since June 24, 2009 to match core CBO assumption fro 7/14/2009

- Start data is January 1, 2013. Previous assumption was January 1, 2010
- Large insurers restricted from buying public plan to mitigate crowd out

Summary

The plan lowers the uninsured significantly, to less than 19% of the population, but not without a cost of nearly \$2.0 trillion dollars over 10 years. There are limited provisions to cover this offset with pay of place for firms and individuals. **If** the most generous estimate of the employer sponsored tax exclusion (\$300 billion per year, including collecting FICA contributions from employers) were used and combined with fraud

¹ See Feldman, R., Parente, S.T. et al., “Health Savings Accounts: Early Evidence of National Take-up from the 2003 Medicare Modernization Act and Future Policy Proposals,” Health Affairs, 24:6 (November/December, 2005), pp. 1582-1591.

estimates and block granting all of Medicaid (acute and long term care²), this might be able to approach neutrality. Finally, the public plans will be quite successful in recruiting large numbers of Americans if allowed to enter the large group employer market. We constrain the public plans to not able operate the ERISA market as is suggested by the CBO estimates. Even with this restriction, we could crowd out of 9.6 million individual contracts with existing private insurers.

In contrast to the Senate version of this bill, the House version is more fiscally prudent and effective. In part, we are assuming more limited reimbursement of providers through the public plan's Medicare +5% reimbursement and indexing the health plan subsidy to the basic plan as a low or limited option PPO. Of note is a substantial difference in cost, \$300+ billion over ten years, for a very marginal difference in impact. Indexing to the low option will thus reduce cost, but it could also limit access if providers are not adequately compensated to actively participate in the public plan. The ten year cost of this proposal with a medium option minimum benefit is just under \$2.35 trillion dollars. A medium option minimum benefit standard would be similar to a PPO or POS plan design with 15% to 20% coinsurance cost-sharing component with maximum out of pocket expenses of \$10,000. This would make the plan design similar less generous, but competitive health insurance option offered to federal health employees,

² <http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf>, assume bigger \$\$ than acute care

ARCOLA™ Technical Documentation

The ARCOLA™ model is a national health policy impact micro-simulation model designed to estimate the impact of health policy proposals at federal and state levels. The model predicts individual adult responses to proposed policy changes and generalizes to the US population with respect to: 1) health insurance coverage and 2) financial impact of the proposed changes.

This model was first used for the Office of the Assistant Secretary (OASPE) of the Department of Health and Human Services (DHHS) to simulate the effect of the Medicare Modernization Act of 2003 (MMA) on take-up of high-deductible health plans in the individual health insurance market (Feldman, Parente, Abraham et al, 2005; Parente et al, Final Technical Report for DHHS Contract HHSP233200400573P, 2005). The model was later refined to incorporate the effect of prior health status on health plan choice – a necessary step if one wants to predict enrollment more accurately. The latest model also used insurance expenditures from actual claims data to refine premiums and then predict choices again with the new premiums. The model then iterates the choice model until premiums and choices converge, and then finds an equilibrium state. A subsequent change to the model permitted state-specific predictions of policy changes as well as total federal health policy impact.

Model Components & Data Sources

There are three major components to the ARCOLA™ model: 1) Model Estimation; 2) Choice Set Assignment and Prediction; and 3) Policy Simulation. Often, more than one database was required to complete the task. Integral to this analysis was the use of consumer directed health plan data from four large employers working with the study investigators.

The model estimation had several steps. As a first step, we pooled the data from the four employers offering CDHPs to estimate a conditional logistic plan choice model similar to our earlier work (Parente, Feldman and Christianson, 2004). In the second step we used the estimated choice-model coefficients to predict health plan choices for individuals in the MEPS-HC. In order to complete this step, it was necessary first to assign the number and types of health insurance choices that are available to each respondent in the MEPS-HC. For this purpose we turned to the smaller, but more-detailed MEPS Household Component-Insurance Component linked file, which contained the needed information. The third step was to populate the model with appropriate market-based premiums and benefit designs. The final step was to apply plan choice models coefficients to the MEPS data with premium information to get final estimates of take up and subsidy costs.