EXECUTIVE SUMMARY

The Impact of the 2009 The Patient's Choice Act

From Senators Tom Coburn (OK) and Richard Burr (NC), as well as Representatives. Paul Ryan (WI), and Devin Nunes (CA)

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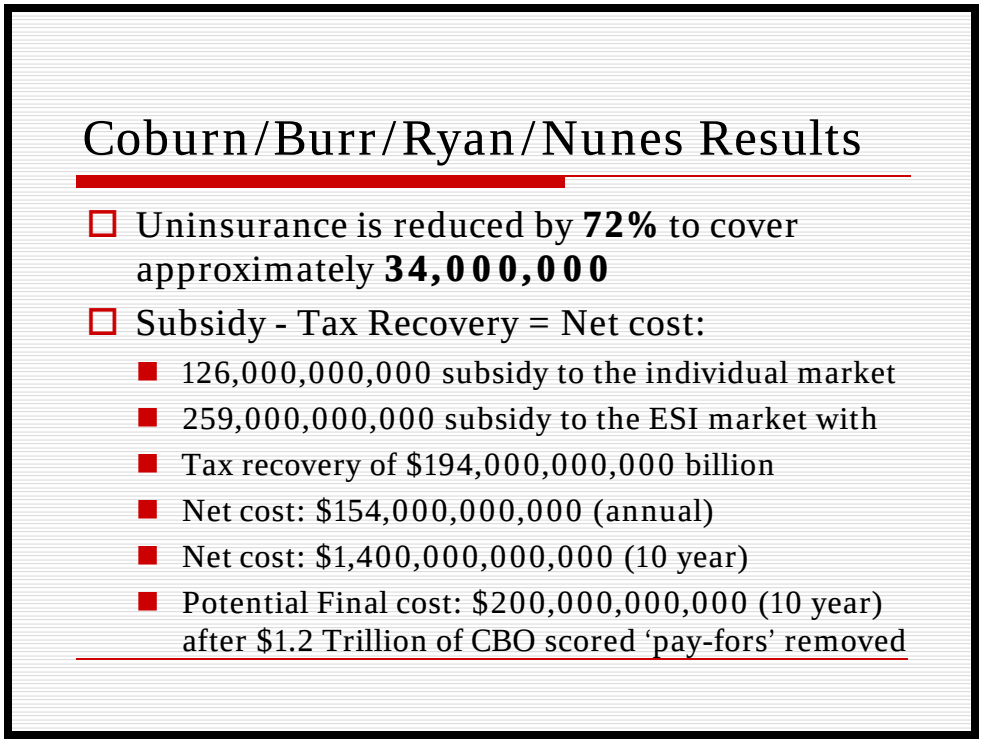
2009 The Patient's Choice Act Score

Independent Assessment by HSI Network LLC
For Public Dissemination

Summary Snapshot

Sens. Tom Coburn (Okla.) and Richard Burr (N.C.), as well as Reps. Paul Ryan (Wisc.), and Devin Nunes (Calif.) have proposed a health reform bill that seeks to reduce the number of uninsured and increase health system efficiency and quality. The proposal provided adequate information to suggest what the impact would be of the Patient Choice Act (PCA) using the ARCOLA™ simulation model. PCA would remove the tax exclusion associated with employer sponsored health insurance and use it to fund advanceable and refundable tax credits to all purchasers of a health insurance plan. This would permit a level playing field for the provision of health insurance. The plan also features an auto-enrollment component as well as an emphasis on prevention and wellness. Below, we summarize the impact of the proposed plan in terms of the reduction on uninsured, the 2010 cost, as well as the ten year cost of the plan in 2010 dollars.



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 Affairs[1] and a longer version is available as a DHHS report at www.ehealthplan.org

Scoring Components

Major Policy Components Scored:

- Providing an advanceable and refundable tax credit of $2,300 per individual or $5,700 per family

- State Insurance Exchanges: Gives states the ability to band together in regional pooling arrangements, and allows the creation of robust high risk pools, reinsurance markets, or risk adjustment mechanisms to cover those deemed 'uninsurable'.

- Equalizes the Tax Treatment of Health Care: Consumers receiving their insurance through the work place would have the value of the benefit provided by the employer taxed.

Summary

The plan lowers the uninsured significantly, by nearly 75%, but not without a cost of over one trillion dollars over 10 years. The taxes recovered by removal of the employer sponsored health benefit tax exclusion are nearly $200 billion per year. While this is a substantial sum of money, it is not sufficient to cover the cost of the tax credits.

The net cost of the plan may be very close to revenue neutral if the following 'pay-fors' scored by the Congressional Budget Office (CBO) were added in (10 year estimates).

- $100B - Change Medicare Advantage to pay 106% above FFS[2]
- $28.3B - Mean-testing Part D[3]
- $556B - Converting Medicaid acute care from defined benefit to defined contribution[4]
- $600B+ - Block granting Medicaid long-term care[5]
- $5.6B Malpractice Liability Reform[6]

With these CBO pay-fors, the 10-year cost is approximately $200 Billion. If one adds in proposed Medicare and Medicaid fraud reductions (not scored by CBO though), the proposal would be cost saving.

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[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.
[2] http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf, p. 122
[3] http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf, p. 164-166
[4] http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf, p. 131
[5] http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf, assume bigger $$ than acute care
[6] http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf, p.21

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.