

EXECUTIVE SUMMARY

U.S. Senate Finance Committee Health Reform 'Public Option' Score

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Completed by:

HSI Network, LLC
Wayzata, MN 55391

For more information contact:

Steve Parente, Ph.D., Principal, sparente@hsinetwork.com, 612-281-8220

Lisa Tomai, M.S., Director, lisa.tomai@hsinetwork.com, 203-448-9249

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*Independent Assessment by HSI Network LLC
For Public Dissemination*

Summary Snapshot

Staffers in the U.S. Senate Finance Committee have released a set of white papers and spoken of a possible Public Option healthcare plan. While there is not yet a specific proposal to score, there is sufficient information to suggest what the impact of the public option design would be, using the ARCOLA™ simulation model. The public option plan consists of a health plan design that would provide an additional health insurance choice to US citizens. One of the key assumptions of public plan simulation is the underlying benefit design package. In addition, the nature and extent of premium supports that will be included in order to increase coverage requires an explicit assumption. 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.

Senate Finance Committee Plan

- Uninsurance is reduced by
 - FEHBP Public **29.8%** or ~ **14,300,000**
 - Massachusetts Public **74 %** or ~ **35,000,00**
 - 2010 annual cost of public plan:
 - FEHBP Public \$154,000,000,000
 - Massachusetts Public \$301,000,000,000
 - Ten year cost:
 - FEHBP Public \$ 1,370,000,000,000
 - Massachusetts Public \$2,680,000,000,000
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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

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.

Scoring Components

Major Policy Components Scored:

- Public Plan as Federal Health Employee Benefit Plan (BCBS-Style PPO): This assumption was made because of the frequent references to FEHBP as a potential plan model for health plan design. The ARCOLA model contains a reference point for medium to high option PPO that is used as favored benefit package for simulation under this scenario.
- Public Plan as a Commercial Low-option PPO: This assumption was made based on the high take-up of narrow network plan designs in Massachusetts as well as high cost sharing network plan designs with lower premiums.
- Regional insurance exchanges: It is assumed that either a national or regional exchange would be used to announce public plan availability as well as pricing, similar to the design of the Massachusetts Connector.
- Direct premium support for Public Plan: It is assumed that up to a 30% discount on the plan will be provided.

Summary

The plan achieves its principal aim of reducing the number of uninsured. The cheaper of the two options is the FEHBP style design – but there is far less uninsured reduction than with the Low-option PPO. This is because the price point of the low-option PPO increases overall take-up much more effectively and, thus, requires more federal dollar support.

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 model coefficients to the MEPS data with premium information to get final estimates of take up and subsidy costs.