

EXECUTIVE SUMMARY

The Impact of the Health Reform Reconciliation Bill

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*Independent Assessment by HSI Network LLC
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Summary Snapshot:

This report summarizes the impact of the Health Reform Reconciliation Bill (modifying H.R. 3590). The legislation proposes to alter the health reform bill passed in the US Senate on 12/24/2009. Below are the major changes in the legislation that are modeled. The analysis focuses principally on the cost of coverage expansion. The major changes in the bill seek to increase the number of uninsured as well as keep the expense of the program below the President's stated aim of \$900 billion dollars. Furthermore, the President wanted a bill that would not add to the deficit.

The results of this analysis show that the reconciliation version of H.R. 3590 would lead to a 10 year cost of the program of \$1.36 trillion. This lead to nearly 31 million people in the United States getting insurance coverage through Medicaid expansion and direct subsidy of private insurance through health insurance exchanges.

Below, a summary of the impact of this proposal is presented in terms of the reduction in uninsured, the one-year cost, and the ten-year cost of the plan in 2010 dollars. The program would begin in 2014 and the 10-year cost estimates are for 2010-2019.

Impact of Health Reform Reconciliation Bill, as of 3/15/2010

- ❑ Uninsurance is reduced by **59.8%** (81% if base is US citizens only) to newly cover approximately **30.7 million people**
- ❑ CBO Estimates – 3/18/2010
 - CBO 10 year cost: \$940 billion
 - CBO deficit savings \$130 billion
- ❑ HSI Estimates – 3/19/2010
 - 10 year cost: \$1.36 trillion
- ❑ Summary: Additional costs will eliminate deficit savings and add to deficit by \$287 billion

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 beyond the Senate bill:

- Makes the tax credits for health insurance premiums more generous for individuals and families with incomes between 250% and 400% of the federal poverty level (FPL)
- Reduces cost-sharing for individuals and families with incomes between 100% and 250% FPL
- Bridges differences between the House and Senate with regard to the maximum proportion of income that middle class individuals will spend on health insurance through the exchange
- Similar to both House and Senate bills, creates refundable tax credits for individuals with incomes between 133% and 400% of the federal poverty line (FPL) to cover the costs of health insurance premiums
- Ties premium credits to the second lowest cost silver plan available through the exchange.
- The maximum proportion of income that individuals will pay for health insurance increases with income, on a sliding scale:
 - Up to 133% FPL 2% of income (unchanged from Senate)
 - 133 – 150% 3% - 4% (4% - 4.6% in Senate)
 - 150% - 200% 4% - 6.3% (unchanged from Senate)
 - 200% - 250% 6.3% - 8.05% (unchanged from Senate)
 - 250% - 300% 8.05% - 9.5% (8.1% - 9.8% in Senate)
 - 300% - 400% 9.5% (9.8% in Senate)
- Relative to the Senate bill, reduces cost-sharing for middle income individuals and families.

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.

- Plans' total contribution toward an individual or family's health care costs declines with income, on a sliding scale:
 - 100% - 150% FPL Plan covers 94% of costs (was 90% in Senate)
 - 150% - 200% FPL Plan covers 87% of costs (was 80% in Senate)
 - 200% - 250% FPL Plan covers 73% of costs (was 70% in Senate)
 - 250% - 400% FPL Plan covers 70% of costs (unchanged)
- All high deductible insurance plans must offer preventive care benefits.
- 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.
- Start date for subsidy is January 1, 2014.

Summary points:

- The plan lowers the uninsured by adding nearly 31 million to the ranks of the insured in 2014. Most of the reduction focused on those with lower incomes.
- The CBO's cost of coverage looks too low at \$940 billion over ten years compared to our \$1.36 trillion cost over ten years.
- Assuming CBO's estimate of \$130 billion deficit reductions is correct, the gap between \$1.36 trillion and \$940 billion is large enough - \$417 billion – to lead to a net ten year addition to the deficit of \$287 billion.

In contrast to the current House and Senate bills, this proposal is less costly than our previous estimates because of the advocacy of HSAs and high deductible plans in the benefit set. However, the bill does little to reduce trends in cost increases of roughly 8% and the additional generosity in benefit subsidies finds consumers in the ARCOLA model 'trading up' to more expensive plans (e.g., from bronze to silver; and from silver to gold).

In conclusion, the bill does address the problem of the uninsured, but at a cost that is not budget neutral. Ultimately, it will lead to a greater deficit in ten years time.

ARCOLA™ Technical Documentation

The ARCOLA™ model is a 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 health insurance coverage and the 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.