



## **Analysis of the July 15 draft of The American Affordable Health Choices Act of 2009**

Prepared for: The Heritage Foundation

Submitted by: The Lewin Group

Date: July 17, 2009 - Revised July 23, 2009

## About The Lewin Group

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# memorandum

July 17, 2009

**Revised July 23, 2009**

To: Stuart Butler; Heritage Foundation: Vice President, Domestic and Economic Policy Studies

From: John Sheils and Randy Haught

RE: Analysis of the July 15 draft of The American Affordable Health Choices Act of 2009

The American Affordable Health Choices Act of 2009 would require all Americans to have health insurance. To assure access to affordable coverage, the bill expands the Medicaid program to cover all adults with incomes below 133 percent of the federal poverty level (FPL) (\$29,300 for a family of four), and provides premium subsidies for people living between 133 percent and 400 percent of the FPL (i.e., \$88,000 for a family of four). It also requires most employers to contribute to the cost of coverage for their workers.

The bill also establishes an “exchange” that presents a selection of health coverage alternatives including a newly created public plan that would compete with private insurers for enrollment. Insurance markets are reformed to assure guaranteed issue of coverage to all applicants regardless of health status. Also, insurers would be prohibited from charging higher premiums on the basis of health status. The Act also includes a series of reductions in spending under Medicare.<sup>1</sup>

In this memorandum, we present estimates of the impact of the Act on sources of insurance coverage and provider incomes. We present our results in the following sections:

- Insurance exchanges and the public plan;
- Medicare payment reforms;
- Coverage effects;
- Detailed physician impacts analysis; and
- Detailed hospital impacts analysis.

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## A. Insurance Exchanges and the Public Plan

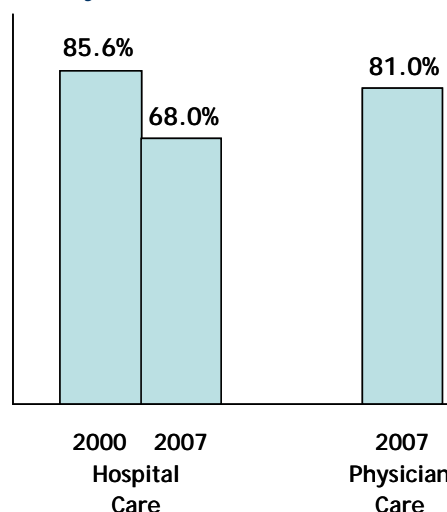
The Act would establish a nationwide network of health insurance exchanges. The exchange would provide consumers with a selection of health insurance plans competing on the basis of price and quality. It is designed to provide consumers with a transparent marketplace for coverage that features consumer protections and facilitates enrollment. Eligibility to participate in the exchange would be phased in over three years as follows:

- Year 1: Individuals and employers with 10 or fewer workers;
- Year 2: Individuals and employers with 20 or fewer workers; and
- Year 3: Individuals and employers of any size allowed by a newly established “Health Choices Commissioner.”

One of the coverage options offered through the exchange would be a new public plan, modeled on Medicare. Participants would pay actuarially determined premiums set at levels required to pay the full cost of coverage under the public plan. The public plan would be available to anyone eligible to enroll in the exchange. Thus, by the third year of the program individuals and all employers would be eligible to enroll in the public plan.

The public plan would pay health care providers using the Medicare payment methodology. As shown in *Figure 1*, Medicare payments to hospitals are equal to only about 68 percent for what private insurers pay for the same services. In fact, hospital payments as a percentage of private payer rates have declined steadily since 2000. Physician payments are equal to only about 81 percent of what is paid by private insurers for comparable services.

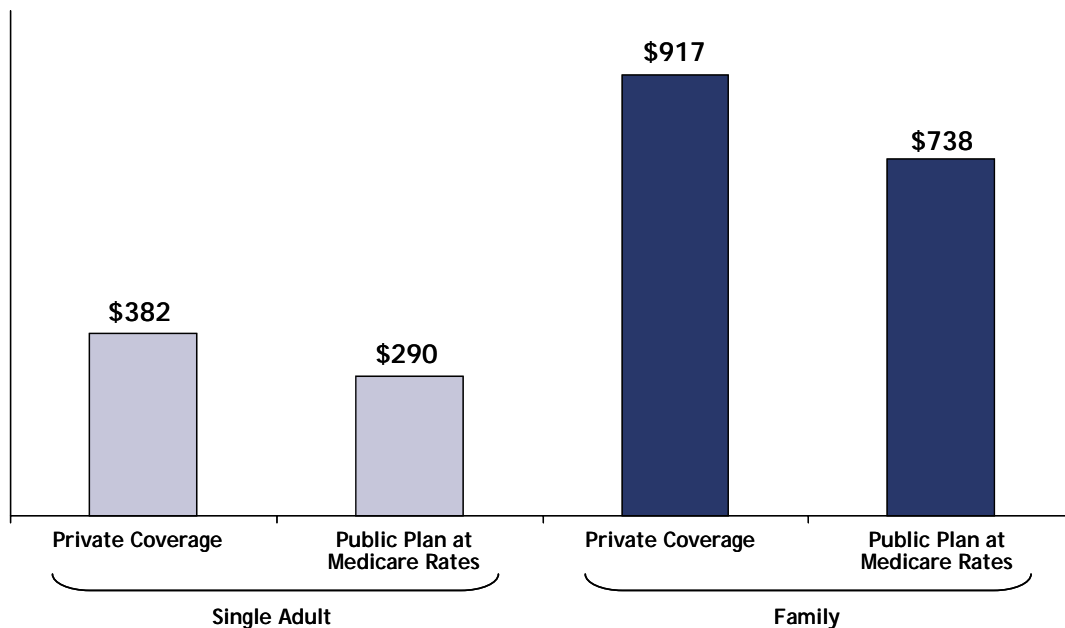
Figure 1  
Medicare Provider Payments as a Percent of Private Payer Rates



Source: American Hospital Association, “Trends Affecting Hospitals and Health Systems,” TrendWatch Chartbook April 2008; “Report to Congress: Medicare Payment Policy,” Medicare Payment Advisory Commission (MedPAC), March 2008; and State Health Facts, The Kaiser Family Foundations (KFF), 2003 report.

Because Medicare pays providers substantially less than private insurers, premiums for the public plan would be substantially less than comparable coverage in a private plan. We estimate that the average premium under the “enhanced” benefits package would be \$917 per month for private coverage compared to \$738 per month under the public plan in 2010 (*Figure 2*). These represent savings of between 20 percent and 25 percent.

**Figure 2**  
 Cost of the “Enhanced” Benefits Package under Private Coverage and the Public Plan under the Act <sup>a/</sup>



a/ Premiums are estimated for people with private coverage under current law. Family coverage includes families, couples and single parent households.  
 Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

These estimates are based upon the demographic and health characteristics of the population eligible to enroll in the exchange. In addition to payment level differences, they reflect differences in administrative costs and the levels of benefit management under plan alternatives. They are adjusted to reflect an increase in cost shifting resulting from the use of Medicare payment rates, which are typically less than the cost of services provided by hospitals to the existing Medicare population. The derivation of these premiums is presented in *Appendix A*.

## B. Medicare Payment Reforms

The Act includes over 80 sections that alter Medicare provider payment policies for virtually all types of providers of health services including physicians, hospitals, home health agencies, skilled nursing facilities, rehabilitation hospitals and other health care practitioners. Several of these changes are designed to encourage improved quality and efficiency such as bundled payments and quality related payments such as pay-for-performance. Total reductions in payments to providers under the bill would be \$361.9 billion (*Figure 3*).

The Act also permanently replaces the “sustainable growth rate” (SGR) formula for Medicare payments to physicians and other health practitioners. This averts the 21 percent reduction to payment levels that is scheduled to occur under current law. However, Congress is expected to act to prevent these payment reductions as they have done in each of the past several years, regardless of health reform. This is also assumed in President Obama’s proposed budget. Consequently, we present our physician-impacts estimates with and without the effects of replacing the SGR.

**Figure 3**  
**CBO Estimates of the Effects of Medicare Reforms under the Act on Provider Incomes: 2010-2019**  
**(billions)**

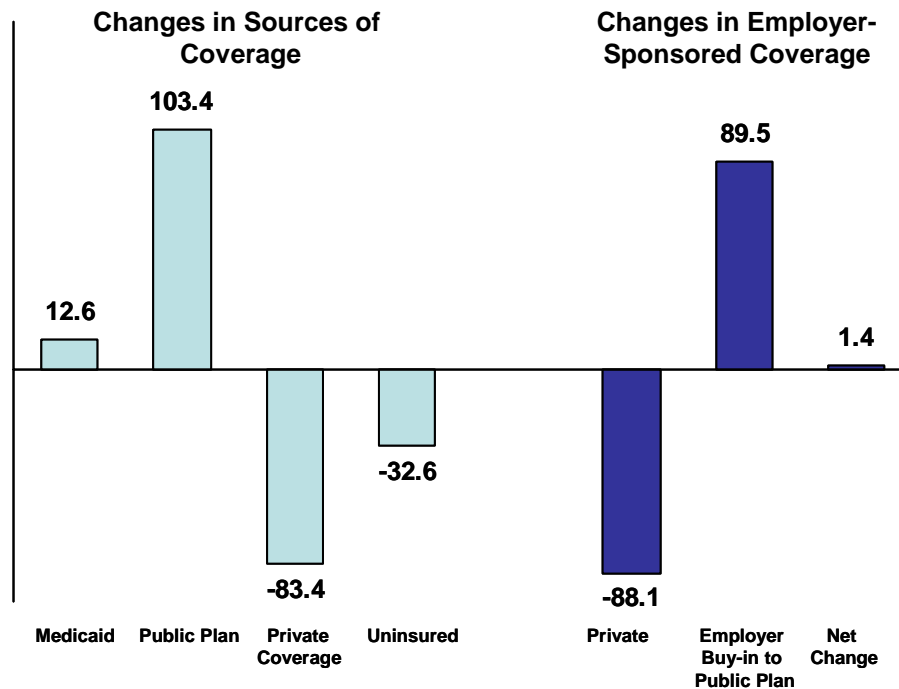
|  | 2010        | 2011        | 2012         | 2013         | 2014         | 2015         | 2016         | 2017         | 2018         | 2019         | 2010-2019     |
|--|-------------|-------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|---------------|
| <b>Changes in Expected Payments to Providers</b> |             |             |              |              |              |              |              |              |              |              |               |
| Hospital   | -2.5        | -3.6        | -6.9         | -10.4        | -23.6        | -24.5        | -26.7        | -35.5        | -41.7        | -45.1        | -220.6        |
| Physician  | 1.5         | 2.9         | 3.8          | 4.1          | -0.8         | 1.3          | 2.8          | 3.0          | 3.3          | 3.8          | 25.6          |
| Other Professional                               | 0.2         | 0.5         | 0.6          | 0.7          | 0.0          | 0.4          | 0.6          | 0.3          | -0.6         | -4.1         | -1.5          |
| Dental   | 0.0         | 0.0         | 0.0          | 0.0          | 0.0          | 0.0          | 0.0          | 0.0          | 0.0          | 0.0          | 0.0           |
| Home Health                                      | 0.0         | 0.2         | 0.1          | -0.1         | -1.0         | -0.7         | -0.5         | -0.6         | -0.7         | -0.8         | -4.3          |
| Prescription Drugs                               | -0.1        | -5.6        | -7.3         | -6.8         | -8.5         | -6.6         | -3.3         | -2.5         | -2.7         | -1.7         | -45.3         |
| Other Non-Durables                               | 0.0         | -0.4        | -0.1         | 0.0          | 0.0          | 0.0          | 0.0          | -0.1         | -0.1         | -0.1         | -0.7          |
| Durables   | 0.0         | 0.1         | 0.1          | 0.1          | -0.2         | 0.0          | 0.1          | 0.1          | 0.1          | 0.1          | 0.5           |
| Nursing Home                                     | -0.9        | -1.3        | -1.4         | -1.8         | -3.2         | -3.2         | -3.5         | -4.2         | -4.7         | -5.5         | -29.7         |
| <b>All Services</b>                              | <b>-1.8</b> | <b>-7.3</b> | <b>-11.0</b> | <b>-14.1</b> | <b>-37.4</b> | <b>-33.4</b> | <b>-30.6</b> | <b>-39.5</b> | <b>-47.3</b> | <b>-53.4</b> | <b>-275.8</b> |
| <b>Other Effects</b>                             |             |             |              |              |              |              |              |              |              |              |               |
| Sustainable Growth Rate                          | 7.4         | 13.1        | 15.3         | 17.6         | 20.3         | 23.5         | 27.5         | 31.3         | 34.4         | 38           | 228.4         |
| Medicare Advantage                               | 0           | -4.6        | -10.3        | -14.9        | -18.3        | -19.7        | -20.9        | -22.5        | -24.6        | -26.7        | -162.5        |
| Interactions                                     | 3.1         | 4.8         | 1.9          | 1.1          | -1.2         | -1.3         | -1.6         | -3.7         | -4.9         | -6.2         | -8.0          |
| <b>Total</b>                                     | <b>8.7</b>  | <b>6.0</b>  | <b>-4.1</b>  | <b>-10.3</b> | <b>-36.6</b> | <b>-30.9</b> | <b>-25.6</b> | <b>-34.4</b> | <b>-42.4</b> | <b>-48.3</b> | <b>-219.7</b> |

Source: Congressional Budget Office, Letter to Charles Rangel, Chairman Committee on Ways and Means, U.S. House of Representatives, July 17, 2009, Estimate of the Effects on Direct Spending and Revenues of Divisions B and C and Section 164 of H.R. 3200, The American’s Affordable Health Choices Act, as introduced on July 14, 2009.

### C. Coverage Effects

We estimate that there will be about 49.1 million uninsured people in 2011. Once the program is implemented, we estimate that the number of uninsured people would be reduced by 32.6 million people (*Figure 4*). Enrollment in the expanded Medicaid program would increase by 12.6 million people. This includes about 15.5 million newly enrolled people, less about 2.9 million current enrollees who would become covered by employers who start to offer coverage in response to the mandate.

Figure 4  
 Changes in Sources of Coverage under the American Affordable Health Choices Act Assuming Full Implementation in 2011 (millions)



a/ This scenario assumes that the exchange is open to all individuals and employees in 2011.  
 Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

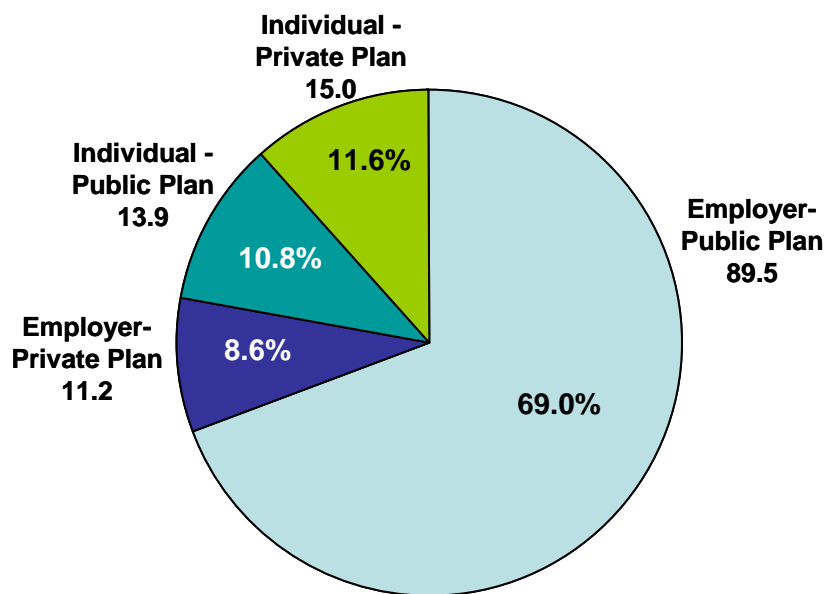
Once fully implemented in year 3 of the program (2015), individuals and all employers would be permitted to participate in the exchange and the public plan. If fully implemented in 2011, we estimate that about 103.9 million people would become covered under the newly established public plan. Coverage under private insurance would decline by 83.4 million people. This is a 48.4 percent reduction in the number of people with private insurance (currently 172.5 million people).

Under current law, there will be about 158.1 million people who are covered under an employer plan as workers, dependents or early retirees in 2011. If the Act was fully implemented in that year, about 88.1 million workers would shift from private employer insurance to other options. However, about 89.5 million people would become covered under the public plan with an employer paying a share of the premium. This is a net increase in the number of people with coverage where the employer is paying a portion of the premium, reflecting the effect of the employer mandate under the Act.

Overall, 129.6 million people would obtain coverage through the exchange (Figure 5). These include about 100.9 million people obtaining coverage with the aid of an employer premium contribution; which includes 89.5 million people covered under the public plan and 11.4 million taking coverage under a private health plan offered in the exchange. About 28.7 million people

would obtain coverage as individuals in the exchange, of whom about half would be enrolled in the public plan. A detailed analysis of changes in sources of coverage is presented in *Appendix B*.

Figure 5  
 Number of People Covered under the Exchange Assuming Full Implementation in 2011 (millions)



**Number Enrolled in Exchange = 129.6**

Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

In *Figures 6 and 7*, we present the distribution of enrollees in the public plan across demographic groups. Enrollees are presented by family income, age of the family head and type of enrollment (employer, individual, recipient of subsidies). In addition, we present workers and dependents by firm size and industry. Estimates are provided separately for people with private employer coverage under current law who shift to the public plan.



























