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**Long-Term Cost of the America's Healthy Future Act of 2009; As Passed by the Senate Finance Committee**

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Date: October 30, 2009

# Table of Contents

## About The Lewin Group

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495261

# Executive Summary

In this study we estimate the impact of The America's Healthy Future Act as adopted by the Senate Finance Committee. The Act would require most Americans to have health insurance. To assure access to affordable coverage, the Bill expands the Medicaid program to 133 percent of the Federal Poverty Level (FPL) for all adults. It also provides a new premium tax credit for people living between 133 percent and 400 percent of the FPL (e.g., $88,000 for a family of four).

In addition, the Act establishes an "exchange" that presents consumers with a selection of health coverage alternatives that is available to individuals and firms with fewer than 100 workers. States would have the option to extend eligibility to larger employers beginning in 2017. Only people participating in the exchange who do not have access to employer coverage would be eligible for the premium tax credit. The Act also reforms insurance markets by assuring guaranteed issue of coverage and prohibiting plans from varying premiums with health status.

Employers with more than 50 workers are required to pay a penalty for each uninsured worker receiving a premium tax credit through the exchange. The Act also provides an employer health insurance tax credit for up to two years for firms with fewer than 25 workers with an average employee earnings of less than $40,000. Workers offered coverage by an employer are not eligible for premium subsides offered in the exchange unless the cost of employer coverage exceeds 10 percent of income.

The Act is funded with reductions in spending under Medicare and Medicaid, a new excise tax on high cost health plans (premiums over $8,000 for individuals and $21,000 for families). It also includes a second excise tax on insurance, new excise taxes on branded prescription drugs and device manufacturers, and other changes in revenues.

In this study we provide estimates of the program's impact on coverage and spending for the federal government, state and local governments, private employers and consumers. To demonstrate the long-term impact of the Act, we provide estimates for a 20-year period from 2010 through 2029.

## Coverage

To illustrate the Act's impacts, we estimated the changes in coverage assuming the program is fully implemented and enrollment is fully matured in 2011. Changes in coverage include:

- The number of people without health insurance would be reduced by 23.9 million people, which is less than half the 49.2 million people who will be uninsured in that year (*Figure ES-1*);

- Of the 25.3 million people who remain uninsured, about 15.4 million are exempt from the penalty, including 3.7 million children, 4.7 million adults below 133 percent of the FPL, 2.0 million adults insured for 3 months or less, and 5.0 million adults who face a premium in excess of 8 percent of income.;

- The Act increases eligibility for Medicaid to 133 percent of the FPL for all adults, resulting in a net increase in Medicaid enrollment of 14.1 million people;

- The number of people with employer-sponsored insurance will decline by 7.3 million people. This includes:

  — About 19.1 million people in firms that drop their coverage once their workers become eligible for subsidized coverage in the exchange; and

  — About 11.8 million people in firms that decide to offer coverage to avoid the penalty.

- The number of people with coverage as an individual would increase from 14.3 million people under current law to 31.4 million people under the Act.

**Figure ES-1**
**Changes in Sources of Coverage under the America's Healthy Future Act Assuming Full Implementation in 2011 (millions) [a]**
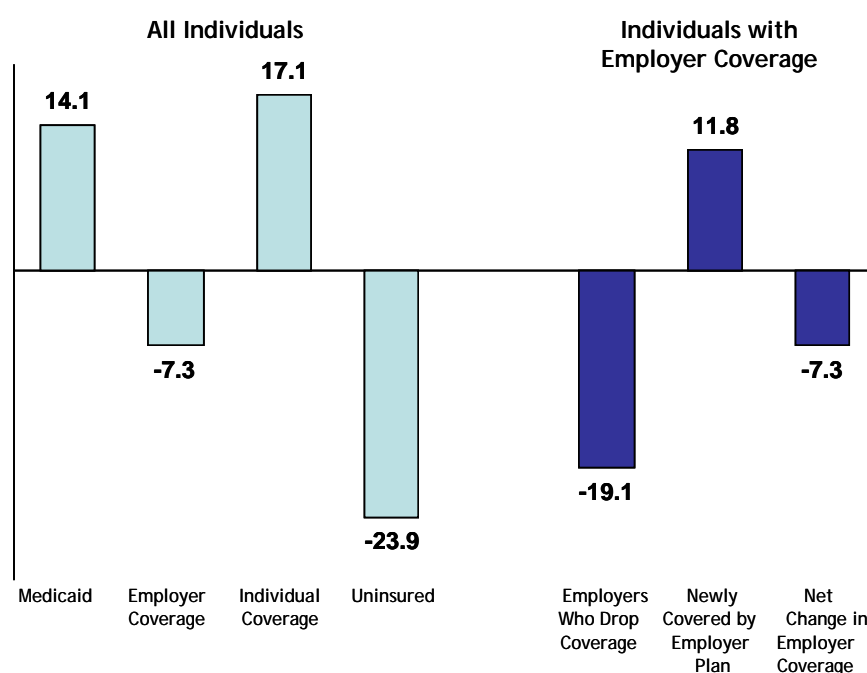


a/ For illustrative purposes, we assume that the program is fully implemented and enrollment is fully mature in 2011. Estimates assume that the exchange is open to individuals and firms with fewer than 50 workers only.
Source: The Lewin Group using the Health Benefits Simulation Model (HBSM).

## Federal Costs

Our analysis shows that the Act is fully funded with the revenues and program savings included in the legislation over both the 2010 through 2019 and 2020 through 2029 period. The Act would reduce the deficit by $15.9 billion in the first decade and $355.4 billion over the second decade (*Figure ES-2*). Key findings include:

- Total benefits costs under the Act would be $875.3 billion the 2010 through 2019 period including the cost of the Medicaid expansion ($329.4 billion), the premium tax credits ($505.7 billion) and the small employer tax credit ($27.2 billion);

3

495261

- There would be program offsets of $291 billion over this period including penalty payments and an excise tax on high-cost health plans;

- Reduced payments under Medicare and Medicaid would save $404.2 billion over the ten-year period; and

- There would be other revenues of $196 billion including new excise taxes on branded prescription drugs ($22.2 billion), medical device manufacturers ($38.6 billion) and a second excise tax on insurers ($60.4 billion).

### Figure ES-2
### Changes in Federal Expenditures and Revenues under the America's Healthy Future Act of 2009: 2010-2019 (billions)

| | Spending for 2010 - 2019 | Spending for 2020 - 2029 | Spending for 2010 - 2029 |
|---|---|---|---|
| **New Program Costs** | | | |
| New Program Costs | | | |
| Medicaid Eligibility Expansion | $329.4 | $1,124.4 | $1,453.7 |
| Premium Subsidies | $505.7 | $1,490.7 | $1,996.5 |
| Employer Tax Credit | $27.2 | $36.3 | $63.5 |
| Retiree Reinsurance Program | $5.0 | $0.0 | $5.0 |
| High Risk Pool/Co-op Funding | $8.0 | $0.0 | $8.0 |
| Total Program Costs | $875.3 | $2,651.4 | $3,526.7 |
| Program Offsets | | | |
| Employer Penalty Payments | $64.8 | $149.2 | $214.0 |
| Penalties for Uninsured | $17.6 | $47.6 | $65.1 |
| Changes in Other Federal Programs | -$18.9 | -$77.9 | -$96.9 |
| Taxes on Changes in Wages | -$12.9 | -$135.9 | -$148.9 |
| Tax on High Cost Insurance | $240.5 | $1,336.6 | $1,577.1 |
| Total Offsets | $291.0 | $1,319.4 | $1,610.4 |
| **Net Federal Cost of Programs** | | | |
| Net Federal Cost | $584.3 | $1,332.0 | $1,916.3 |
| **Financing** | | | |
| Medicare and Medicaid Payment Reforms [a] | -$404.2 | -$1,386.1 | -$1,790.3 |
| Other Revenue Measures [b] | $196.0 | $301.3 | $497.3 |
| **Net Federal Cost** | | | |
| Net Federal Cost of Reform | -$15.9 | -$355.4 | -$371.3 |

a/ Based on Congressional Budget Office (CBO) estimates for 2010 through 2019.
b/ Based on Joint Committee on Taxation (JCT) estimates for 2010 through 2019.
Source: The Lewin Group Health Benefits Simulation Model (HBSM).

The Act imposes an excise of 40 percent of the cost of insurance in excess of $8,000 for individuals and $21,000 for families. Revenues from the tax would grow faster than the growth in benefits costs because the thresholds would be indexed over time at only about half the rate of growth in health care spending (i.e., CPI plus one percent).

- The tax would raise $240.5 billion over the 2010 through 2019 period;

- The tax would affect coverage for 33.3 million people when first implemented in 2013, of whom 3.1 million would be retirees;

- The number of people in affected plans would grow to 60.5 million people in 2019 and 110.7 million people by 2029; and

- Revenues over the 2020 through 2029 period would be $1.3 trillion.

## State and Local Governments

We estimate that the Act would result in a net savings to state and local governments of about $63.7 billion over the 2010 through 2019 period, primarily due to savings in safety-net programs that now serve the uninsured. States would save about $121.9 billion over the 2020 through 2029 period.

- States would be required to pay roughly 10 percent of the cost of the Medicaid expansion beginning in 2014, which would be $14.4 billion over the 2010 through 2019 period;

- Health benefit costs for state and local government workers would increase by about $45.4 billion over the 2010 through 2019 period reflecting the cost of the excise taxes and costs of either covering uninsured workers, or paying the employer penalty described above; and

- State and local governments would save $122.2 billion on spending for safety-net programs resulting from the reduction in the number of uninsured.

## Private Employers

The Act requires employers with 50 or more workers to either provide coverage or pay a penalty for each uninsured worker receiving the premium tax credit equal to the national average credit amount. An employer's liability is capped at $400 times the number of fulltime workers. Also, the Act provides a tax credit to lower-wage firms with fewer than 25 workers for the purchase of coverage.

- In the early years of the program, firms that currently offer insurance would see a reduction in annual health spending of $268 per worker. This would be primarily for firms that discontinue their health plans once subsidized coverage becomes available to their workers under the Act (*Figure ES-3*);

- Costs for firms that do not now offer coverage would increase by an average of about $301 per worker;

- Small insuring firms would save up to an average of $950 per worker due to the small employer tax credit;

- After 2016, employer spending would increase steadily under the Act reflecting the cost of paying the various excise taxes under the Act. Total employer health spending would increase by 2.1 percent by 2019; and

- These estimates reflect increases in cost-shifting under the Act and assume that the cost of the excise tax payments will be passed on to employers and consumers in premiums, adjusted for a consumer price response.

**Figure ES-3**
**Average Annual Change in Employer Costs per Worker by**
**Current Insuring Status and Firm Size: 2011**
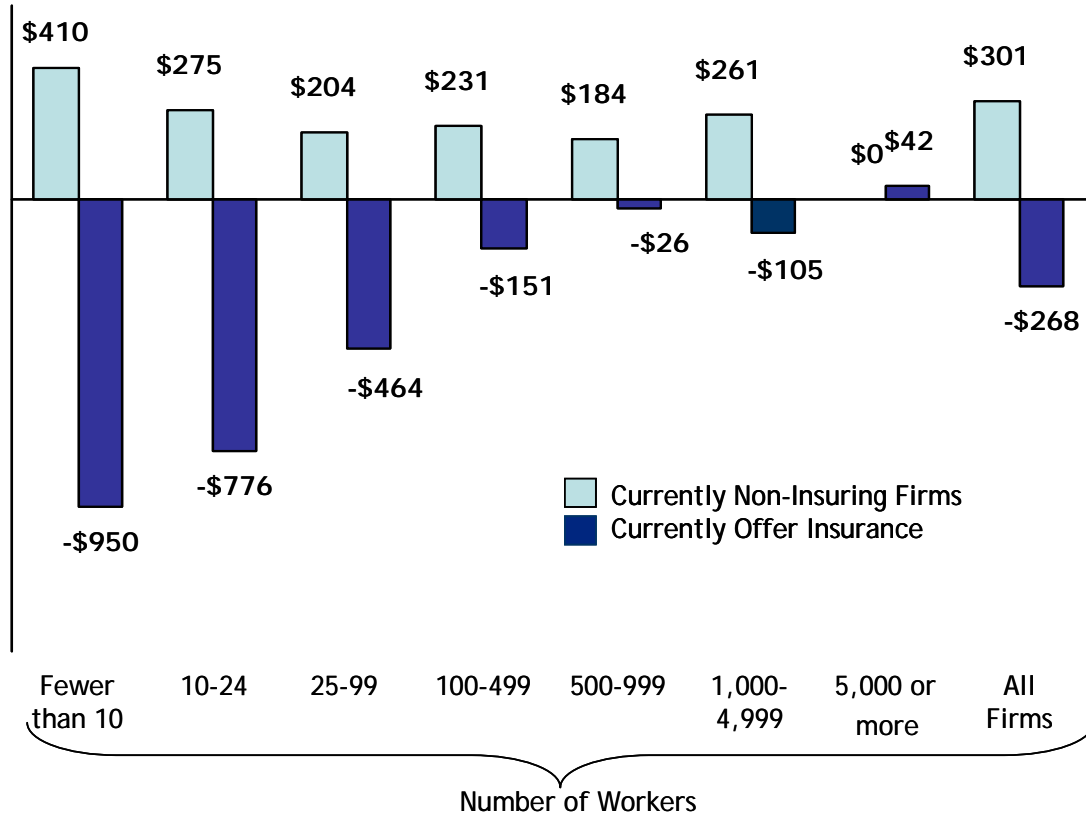


a/ For illustrative purposes, these estimates assume that the Act is fully implemented and enrollment is fully matured in 2011.
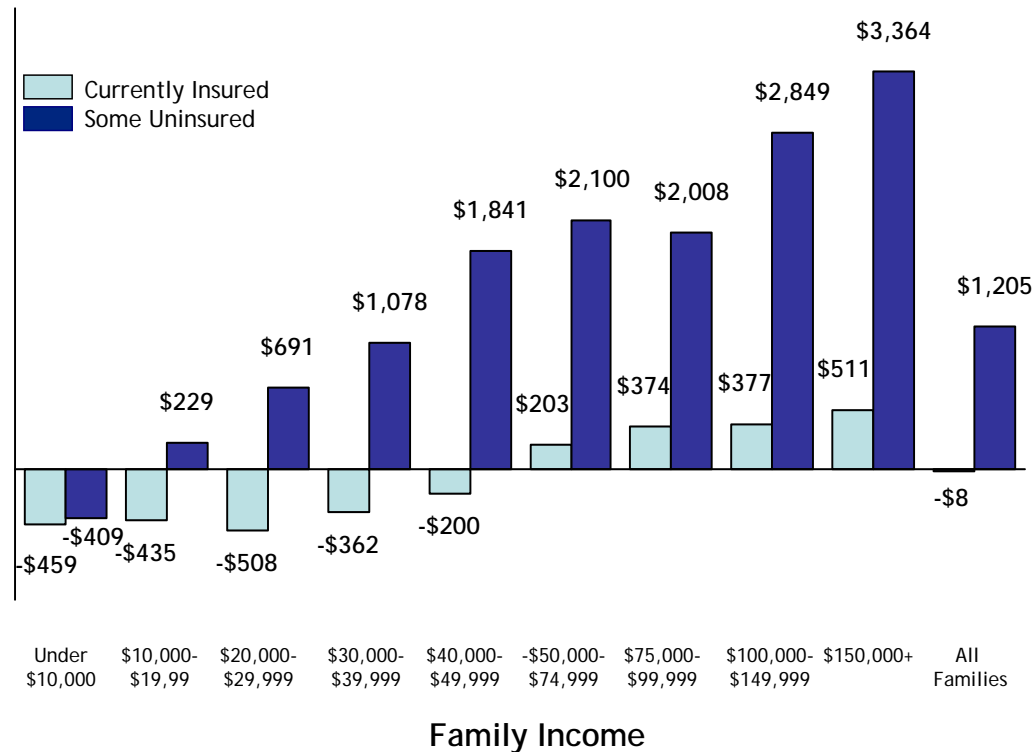Source: Lewin Group Estimates Using the Health Benefits Simulation Model (HBSM).

## Impacts on Families

Under current law, families will spend an average of about $4,192 per family for health care in 2011. This includes average family premium payments of $2,648, including employee contributions to employer coverage. It also includes average out-of-pocket expenses for insurance co-payments and uncovered health services of $1,544.

- Average health spending would increase by about $218 per family under, primarily due to increased premium payments for newly insured people;

- Insured families with income below $50,000 would on average see savings averaging up to $500 per family (*Figure ES-4*); and

6

495261

- Families with one or more uninsured members would on average see an increase in family health spending of $1,205 per family.

**Figure ES-4**
**Changes in Average Annual Family Health Spending by Family Income and Current Insured Status under the America's Healthy Future Act, Assuming Implementation in 2011[a]**



a/ For illustrative purposes, this scenario Assumes that the Act is fully implemented and enrollment is fully matured in 2011.
Source:  The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

## Impact on National Health Spending

National health spending will reach $2.77 trillion in 2011, including payments for all health care providers by all public and private payers and households. Under the Act:

- Total national health spending would increase by about $35 billion in the earliest years of the program, which is an increase of only about one tenth of one percent;

- The increase in national health spending would be $114.2 billion over the 2010 through 2019 period and $527.4 billion over the 2020 through 2029 period; and

- Most of the increase in spending would be attributed to increased utilization of health services by newly insured people.

495261

## Cost Shifting

The proposal would reduce spending under public programs by about $404.2 billion over the 2010 through 2019 period, of which about two thirds ($241.9 billion) would be in the form of reduced payments to providers for health services. These reductions in provider reimbursement would be partly offset by reductions in uncompensated care of $151.4 billion over this period. Historically, about 40 percent of these reductions in revenues have been passed back to private payers in the form of higher charges. We estimate that:

- The Act would increase the total amount of the cost-shift by about $8.6 billion in 2014, rising to $25.8 billion in 2019;

- Total cost shifting over the 2010 through 2019 period would be $34.4 billion;

- The cost shift would rise to $190.9 billion over the 2020 through 2029 period; and

- The cost shift would affect premiums for all employers including government workers health benefits, and premium payments by individuals.

## A. The America's Healthy Future Act of 2009

We were asked to estimate the cost and coverage impacts of the America's Healthy Future Act of 2009, as adopted by the Senate Finance Committee. The Act would require most 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 a premium tax credit for people living between 133 percent and 400 percent of the FPL (i.e., $88,000 for a family of four). It also requires employers to pay a penalty based upon the number of their fulltime workers who receive the premium tax credit.

In addition, the Act establishes an "exchange" that presents a selection of health coverage alternatives. Insurance markets are reformed to assure guaranteed issue of coverage to all applicants regardless of health status. Furthermore, insurers would be prohibited from charging higher premiums on the basis of health status. The key provisions of the Bill are summarized below.

### 1. Reforming the Insurance Markets

The Act would establish a nationwide network of state-based 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. The exchange would be available to individuals and firms with fewer than 100 workers. States would have the option to extend eligibility to larger employers beginning in 2017.

**Premium Rating Practices:** The Act eliminates the practice of "medical underwriting." This requires insurers to guarantee issue coverage to all applicants without pre-existing health conditions, and prohibits insurers from charging more for people with a history of illness. The Act also eliminates lifetime and annual limits on benefits. These insurance reforms apply to all coverage sold inside and outside of the exchange.

Premiums in the individual market are permitted to vary by geographic area, and family type (i.e., single, family with child etc.). Premiums may vary with age within a rating band of 4:1. Insurers may also vary premiums with tobacco use by a factor of 1.5:1. These same rules would be phased-in for the small group market over a period of 5 years. In addition, the Act provides funding for high-risk pools for individuals who have been denied coverage, which would be available until 2013 when the insurance market reforms are to be fully implemented.

The Act requires all plans in the individual and small group markets (defined to include firms with 1 to 50 workers) participate in a risk adjustment system designed to correct for any systematic accumulation of high-cost cases in individual health plans. Also, to stabilize the market in the early years of the program, all insurers participating in the individual market are required to participate in a reinsurance program funded with assessments on all insurers during 2013, 2014 and 2015.

**Benefits Packages:** The Act establishes actuarial standards for all policies sold on the individuals and small group markets. These plans must have no cost-sharing requirements for

preventive care services (except in cases where value-based benefits design is used). The Secretary would be required to review and update these lists of covered services on a regular basis. The minimum services that must be covered include:

- Preventive and primary care;

- Emergency services;

- Inpatient hospital services;

- Outpatient hospital services;

- Day surgery and anesthesia;

- Physician services;

- Diagnostic imaging and screening;

- Pediatric services including dental and vision care;

- Maternity services and newborn care;

- Prescription drugs including the class and category of drug coverage requirements specified under Medicare Part D;

- Medical/surgical care;

- Radiation and chemotherapy; and

- Mental Health and Substance abuse treatment.

The Act specifies four different levels of benefit packages, all of which cover these same services. The Act denominates these four benefits packages in terms of their "actuarial value." A benefits package that covers all of the services listed above without cost-sharing (deductibles, copayments, etc.) is defined to have an actuarial value of 1.0. The actuarial value falls as cost sharing amounts increase under these benefits options. These four benefits packages include:

- *Bronze Package*: Includes the core set of covered benefits and a level of cost sharing giving the plan an actuarial value of 65;

- *Silver Package*: Includes the core set of covered benefits with more generous cost sharing giving the package an actuarial value of 70;

- *Gold Package*: Includes the core set of covered benefits with cost sharing that puts the package at an actuarial value of 80; and

- *Platinum Package*: Includes the core set of covered benefits with cost-sharing putting the package at an actuarial value of 90.

All four of these benefit levels would have an out-of pocket limit equal to the minimum under Health Savings Accounts (HSAs) (i.e., $5,950 for individuals and $11,900 for families), which is reduced for people below 400 percent of the FPL. There would be no lifetime limit on covered services under any of these benefits packages. A separate "young invincible" policy would be available for those aged 25 or younger that provides catastrophic protection using the HSA out-of-pocket spending limit. Also, small employers purchasing coverage through the exchange

495261

must purchase a policy with a deductible that does not exceed $2,000 for individuals and $4,000 for families.

However, the actual cost-sharing requirements used under each benefits package are not specified in the Act, and are permitted to differ across health insurers. To illustrate their likely coverage characteristics, we estimated example combinations of deductibles and co-payment amounts for covered services that would correspond to each of four actuarial value standards. These illustrative cost-sharing amounts are presented in *Figure 1*.

**Figure 1**
**Illustrative Cost-Sharing Amounts Consistent with Actuarial Valuation of Health Plan Options** [a]

|  | Senate Finance Committee Benefits Packages | | | | |
|---|---|---|---|---|---|
|  | Without Cost Sharing | Platinum Package | Gold Package | Silver Package | Bronze Package |
| Actuarial Value | 100% | 90% | 80% | 70% | 65% |
| Hospital Deductible | $0 | $100 | $400 | $1,500 | $2,500 |
| Hospital Coinsurance | 0% | 10% | 15% | 25% | 30% |
| Medical Deductible |  |  |  |  |  |
| Single | $0 | $100 | $400 | $1,500 | $2,500 |
| Family | $0 | $200 | $800 | $3,000 | $5,000 |
| Medical Coinsurance | 0% | 10% | 25% | 30% | 35% |
| Prescription Drugs | 0% | 10% | 25% | 30% | 35% |
| Preventive Care | 0% | 0% | 0% | 0% | 0% |
| Out-of-Pocket Limit |  |  |  |  |  |
| Single | $0 | $5,950 | $5,950 | $5,950 | $5,950 |
| Family | $0 | $11,900 | $11,900 | $11,900 | $11,900 |
| Per Member Per Month (PMPM) in 2011 | $424 | $382 | $339 | $297 | $276 |

a/ Estimates developed using Medical Expenditure Panel Survey (MEPS) data for people currently covered under employer plans. We assumed that the intent of the Bill is to set these benefits on the basis of differences in cost-sharing only and does not include the utilization response at various levels of cost sharing. Cost sharing parameters under these benefits packages would be somewhat lower if the utilization response is incorporated into the estimates.
Source:  Lewin Group Estimates using the Health Benefits Simulation Model (HBSM)

## 2. *Individual Responsibility*

The program requires most individuals to have health insurance. Individuals must show proof of coverage when they file income taxes. People who do not have coverage are required to pay an excise tax penalty of $750 per uninsured adult. The penalty would be phased-in between 2014 and 2017. The penalty does not apply to children. It also does not apply to adults with incomes below 133 percent of the FPL or adults who have were uninsured for 3 months or less. Also, people are exempt from the coverage requirement if the cost of the lowest cost option available to them exceeds 8 percent of income. Available coverage includes individual coverage and employer coverage if offered.

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495261

To promote the affordability of coverage, the Act expands eligibility for Medicaid and provides a new tax credit for individuals purchasing insurance in the newly created exchanges.

**Medicaid eligibility:** Eligibility for Medicaid and the Children's Health Insurance Program (CHIP) often varies substantially across states. Under current law, children are typically eligible for either Medicaid or the CHIP programs if their family income is less than 200 percent of the FPL, although many states have higher income eligibility levels for children. Pregnant women are typically eligible through 150 percent of the FPL.

Although eligibility varies by state, custodial parents are typically eligible for Medicaid if their income is below an average of about 50 percent of the FPL. Also, in most states, non-disabled adults without custodial responsibilities for children (i.e., non-custodial adults) are not eligible at any level of income (*Figure 2*). Under the Act, all individuals and families are eligible if their income is below 133 percent of the FPL beginning in 2014.

The Act requires states to maintain existing income eligibility levels until the exchanges are established in 2013. Beginning in 2014, income disregards would no longer apply in determining eligibility.[1] Eligibility would be based upon modified gross income. People losing coverage as a result are expected to be eligible for the new premium assistance program described below unless they are offered coverage by an employer. The CHIP program would be retained in its current form.

**Figure 2**
**Medicaid and CHIP Eligibility for a "Typical State" Under Current Law** [a]
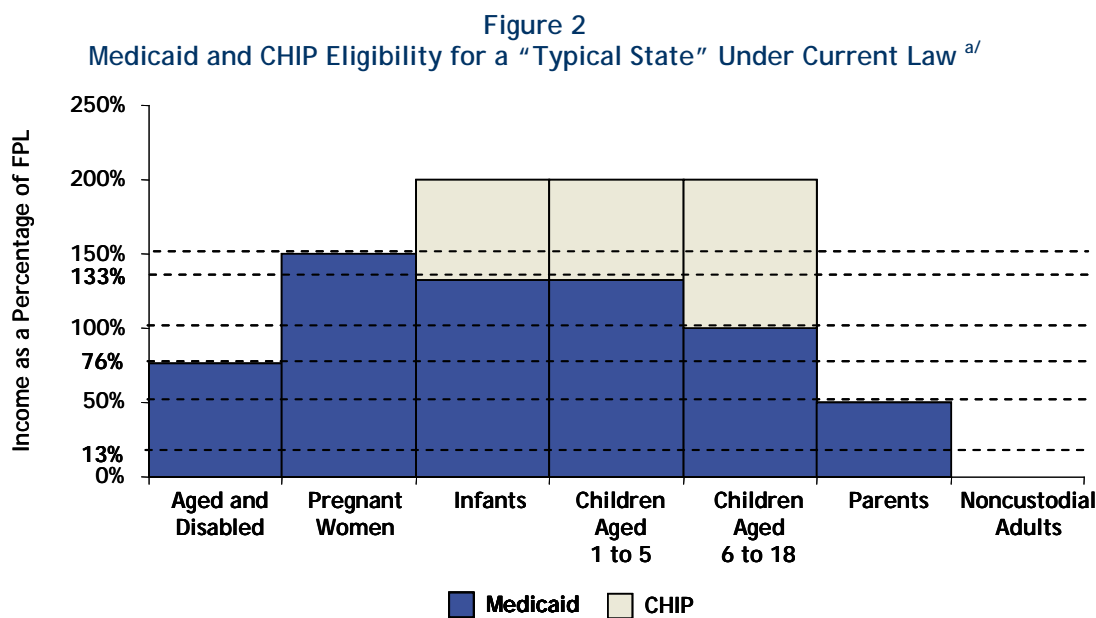


a/ Figures are roughly based upon average income eligibility levels across states by eligibility group.
Source: Program data from the Centers for Medicare and Medicaid Services.

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1    Under current law, states have had the option to use income disregards as a means of increasing income eligibility levels for the program.

The federal government currently matches state spending for the Medicaid program according to a Federal Medical Assistance Percentage (FMAP). Federal matching rates vary across states based upon differences in state income levels and economic characteristics. Although the federal contribution amount varies by state, the federal government currently pays for about 57 percent of the Medicaid program and about 71 percent of the CHIP program.

Under the Act, the existing FMAP would remain at their current levels for currently eligible groups. The Act specifies a new formula for setting the matching rate for newly eligible populations that initially provides greater assistance to state that have not already covered at least some of the newly eligible groups. However, these matching rates would be adjusted each year so that by 2019, the matching rate for the newly eligible groups is the same for all states.

Under this formula, roughly 90 percent of costs for the newly eligible groups would be paid by the federal government. Using this formula, we estimated the weighted average federal matching rate for the newly eligible based upon a Lewin Group analysis of the number of people newly eligible for the program by state for the following years:

|      |       |
|------|-------|
| 2014: | 91.7% |
| 2015: | 91.5% |
| 2016: | 91.1% |
| 2017: | 90.8% |
| 2018: | 90.5% |
| 2019: | 89.7% |

**Premium Subsidies:** The Act also provides a refundable premium tax credit for the purchase of coverage through the state exchanges. The credits would be based on cost of the premium as a percentage of income. The credit would limit family premium payments as a percentage of income, ranging from 2 percent of income for people at 100 percent of the FPL to 12 percent of income for those at 300 percent of the FPL. A cap of 12 percent of income would apply for people with incomes between 300 percent and 400 percent of the FPL.

In most cases, these subsidies are available only to people participating in the exchange as individuals who do not have access to employer-sponsored insurance (ESI). However, as explained below, workers who are offered employer coverage may be eligible for the credit if the employer plan has an actuarial value of less than 65, or the employee share of the premium is greater than 10 percent of the worker's income.

**Cost-sharing Subsidies:** The program also limits family out-of-pocket spending by "buying up" the premium for eligible individuals to cover a greater share of cost-sharing. The subsidy would bring the actuarial value of coverage to 90 percent for people between 100 percent and 150 percent of the FPL, and 80 percent for people living between 150 percent and 200 percent of the FPL. These subsidies are available only to those participating in the exchange as individuals. People covered under the exchange by an employer do not qualify for subsidies.

### 3. Employer Responsibility

Employers are not required to cover their workers. However, the Act does provide a tax credit to small employers for up to half of their cost of health insurance. Also, employers with 50 or

more employees who do not offer coverage are required to pay a flat dollar penalty for each employee receiving a tax credit in the state exchange.

**Employer Penalty Fee:** The flat dollar fee would be equal to the national average tax credit under the program. The fee is capped for all employers at an amount equal to $400 multiplied by the number of fulltime employees in the firm, regardless of the number receiving a credit. Thus, the employer would pay the lesser of the flat dollar amount multiplied by the number of fulltime workers receiving a tax credit, or a fee of $400 for each fulltime worker. These payments would be paid to the general fund.

As discussed above, workers offered coverage by the employer are generally ineligible for the tax credit. However, an employee who is offered coverage that does not have an actuarial value of at least 65 percent, or who is offered coverage that is "unaffordable" may receive the tax credit. Coverage is defined to be unaffordable if the premium exceeds 10 percent of employee income.

**Small Employer Tax Credit:** The Act also provides employers with fewer than 25 fulltime equivalent (FTE) workers a tax credit for the purchase of insurance for their workers. The tax credit for eligible firms is potentially equal to 35 percent of employer contributions for qualified coverage in 2011 and 2012. Beginning in 2013, the credit is potentially equal to 50 percent of employer contributions. The amount of the credit is phased-out for firms with average annual earnings per worker between $20,000 and $40,000. The amount of the credit is also phased-out for employers with between 10 and 25 employees.

Beginning in 2013, the credit is available only to firms purchasing coverage through the state exchange. The credit would be available for the first two years a qualified firm purchases coverage. The credit is not advanceable and is not refundable (i.e., the credit may not exceed the amount an employer's tax liability). The tax credit amount for tax exempt organizations is limited to 25 percent in 2011 and 2012, and 35 percent in 2013 and thereafter.

In addition, the Act provides $5.0 billion in funding for a reinsurance program that would assist employers sponsoring retiree benefits plans. The program would cover expenses in eligible firms for individual retirees with high expenditures. The program would cover 80 percent of costs between $15,000 and $90,000. This assistance would be available in 2013, 2014 and 2015.

### 4.   Other Financing Measures

The Act would be funded with savings to the Medicare and Medicaid programs as well as several new revenue raising measures.

**Reduction in Medicare and Medicaid Spending**: The Act includes an extensive list of changes 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. CBO estimates that these changes would result in net savings of $404.2 billion over the 2010 through 2019 period (*Figure 3*).

**Figure 3**
**CBO Estimates of the Effects of Medicare and Medicaid Provisions under the Act on Provider Revenues: 2010-2019**
**(billions)**

| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2010-2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Medicaid Program** | -$0.4 | -$1.0 | -$1.4 | -$1.4 | -$2.7 | -$3.4 | -$4.5 | -$3.9 | -$3.7 | -$5.3 | -$27.7 |
| DSH Payments | $0.0 | $0.0 | $0.0 | $0.0 | -$2.2 | -$2.9 | -$4.1 | -$4.2 | -$4.3 | -$4.5 | -$22.2 |
| Other Medicaid | -$0.4 | -$1.0 | -$1.4 | -$1.4 | -$0.5 | -$0.5 | -$0.4 | $0.3 | $0.6 | -$0.8 | -$5.5 |
| **Medicare Advantage Payments** | $0.0 | -$6.2 | -$6.6 | -$10.3 | -$11.0 | -$12.2 | -$13.9 | -$16.7 | -$18.9 | -$21.5 | -$117.3 |
| **Medicare Provider Payments** | -$0.4 | -$1.7 | -$4.7 | -$9.2 | -$14.1 | -$19.8 | -$26.1 | -$32.6 | -$39.3 | -$47.4 | -$195.3 |
| Hospitals paid under the inpatient PPS | -$0.3 | -$0.8 | -$2.9 | -$5.5 | -$8.1 | -$10.9 | -$13.8 | -$17.2 | -$21.1 | -$25.9 | -$106.5 |
| Skilled Nursing facilities | $0.0 | $0.0 | -$0.3 | -$0.7 | -$1.1 | -$1.5 | -$1.9 | -$2.4 | -$3.0 | -$3.7 | -$14.6 |
| Hospice | $0.0 | $0.0 | $0.0 | -$0.3 | -$0.5 | -$0.8 | -$1.0 | -$1.4 | -$1.7 | -$2.1 | -$7.8 |
| Home health | -$0.1 | -$0.5 | -$0.7 | -$1.4 | -$2.5 | -$4.1 | -$6.3 | -$7.9 | -$9.1 | -$10.6 | -$43.2 |
| Part B fee schedules, except physicians' services | $0.0 | -$0.4 | -$0.8 | -$1.3 | -$1.9 | -$2.5 | -$3.1 | -$3.7 | -$4.4 | -$5.1 | -$23.2 |
| **Medicare DSH** | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | -$4.0 | -$4.3 | -$4.7 | -$4.6 | -$4.9 | -$22.5 |
| **Medicare Commission** | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | -$1.5 | -$3.1 | -$4.3 | -$6.2 | -$7.1 | -$22.2 |
| **Other Changes** | $9.8 | $8.3 | $1.8 | -$0.1 | -$13.9 | -$5.8 | -$2.8 | -$3.8 | -$5.4 | -$7.3 | -$19.2 |
| **Total Change in Spending** | $9.0 | -$0.6 | -$10.9 | -$21.0 | -$41.7 | -$46.7 | -$54.7 | -$66.0 | -$78.1 | -$93.5 | -$404.2 |

Source: Congressional Budget Office, Letter to the Honorable Max Baucus, Chairman, Committee on Finance, U.S. Senate, from Douglas W. Elmendorf, Director, The Congressional Budget Office, October 7, 2009

About half of the proposed savings ($195.3 billion) would be attributed to changes in provider payments for services. The Act also revises the competitive bidding process for Medicare Advantage that would result in savings of about $117.3 billion. The Act does not change the "sustainable growth rate" (SGR) formula for Medicare payments to physicians and other health practitioners.

The Act reduces Disproportionate Share Hospital (DSH) payments under the Medicare and Medicaid programs to reflect the expansions in coverage under the bill. Medicare DSH payments would be reduced by $22.5 billion over the 2015 through 2019 period, while Medicaid DSH payments would be reduced by $22.2 billion between 2014 and 2019.

In addition, the Act also includes several provisions designed to encourage improved quality and efficiency through bundled payments and quality driven payments such as pay-for-performance. The Act also creates a new "Medicare Commission" charged with developing proposals that would reduce costs in the Medicare program.

**Excise Taxes:** The Act creates new excise taxes on insurance, prescription drugs and durable medical equipment. The largest of these would be an excise tax on high-cost insurance plans. Under this provision, insurers pay a tax equal to 40 percent of the amount by which annual health benefits costs for an employer health plan exceeds $8,000 for individuals and $21,000 for families beginning in 2013. Insurers pay the excise tax based upon data provider by the employer. In self-funded plans, the excise tax is paid by the plan administrator or the employer in self-administered plans. The threshold is increased by $1,850 for individuals and $5,000 for families for workers in high risk occupations and retirees age 55 through 64.

These thresholds are indexed each year by the Consumer Price Index (CPI) plus one percentage point. Because health care costs are expected to grow at nearly double that rate, the number of health plans affected and the amounts subject to the tax would increase over time. We estimate that this will raise revenues of about $240.5 billion over the 2010 through 2019 period.

The Act also includes additional excise taxes that the Joint Committee on Taxation (JCT) estimates will result in an additional $121.2 billion in revenues over ten years. These include:

- An excise tax on fully insured health plans ($60.4 billion);
- A fee on manufacturers and importers of branded drugs ($22.2 billion); and
- A fee on manufacturers and importers of certain medical devices ($38.6 billion).

We assume that these costs would be passed back to consumers in the form of higher prices. For example, the fees on drugs and medical devices would be passed back to insurers and individuals as higher prices. Similarly, the excise taxes on insurance would be passed back to employers and individuals in the form of higher prices.

We assume that this rise in prices would be associated with a reduction in consumer demand which translates to a real reduction in health spending. However, consumer demand for health services has been measured to be largely insensitive to price increases. Based upon available

research, we estimate that health spending for affected populations would fall by an amount equal to 20 percent of the dollar amount of these excise tax revenues.[2]

**Other Revenue Raising Measurers**: The Act includes an additional $58.5 billion in revenues over the 2010 through 2019 period associated with other changes in the tax code and revenues. These include:

- Increase the penalty for nonqualified health savings account (HSA) distributions to 20 percent ($1.3 billion);

- Conform the medical expense definition for flexible spending arrangements to the medical expense deduction ($5.4 billion);

- Limit health flexible spending arrangements in flexible spending arrangements to $2,500 ($14.6 billion);

- Eliminate deduction for expenses allocable to Medicare Part D subsidy ($5.4 billion);

- Raise the 7.5 percent AGI floor on the medical expense deduction to 10 percent for people under age 65 ($15.2 billion); and

- Other tax provisions ($16.6 billion).

CBO and JCT estimate an addition $16.3 billion in revenues over the 2010 through 2019 under various provisions of the Act including fraud waste and abuse provisions, premium taxes for outcomes research and revenues due to other changes in premiums.

## B. Coverage Effects

We project that there will be about 49.1 million uninsured people in 2011. We estimate that if the Act were fully implemented in 2011, the number of uninsured would be reduced by 23.9 million people, leaving about 25.3 million people without insurance (*Figure 4*). Thus, we estimate that the program would cover a little less than half of the uninsured.

Enrollment in the expanded Medicaid program would increase by 14.1 million people. This includes about 16.1 million newly enrolled people, less about 2.0 million current enrollees who would become covered in the exchange or by an employer. For example, some employers would decide to offer insurance in response to the employer assessment for employees taking coverage through the exchange.

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[2] W.G. Manning, et al., "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *The American Economic Review*, vol.77, No. 3, June 1987, pp.251-277.

**Figure 4**
**Changes in Sources of Coverage under the America's Healthy Future Act Assuming Full Implementation in 2011 (millions) [a/]**
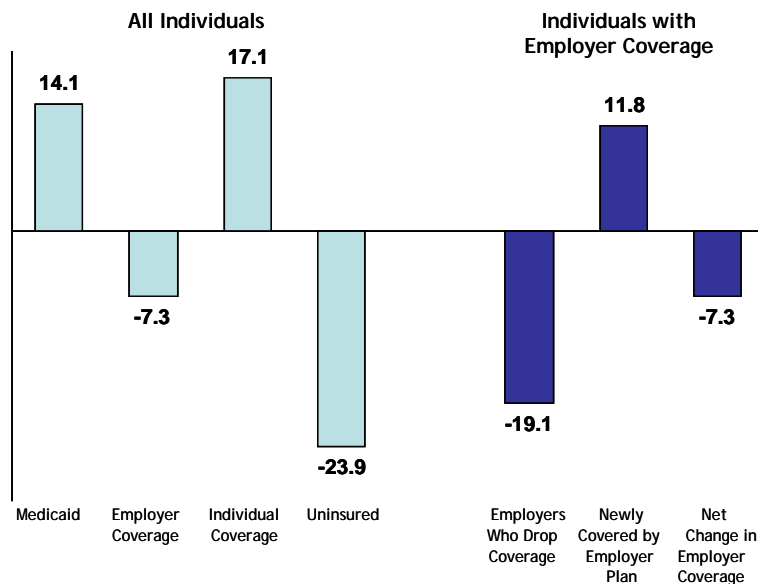


a/ For illustrative purposes, we assume that the program is fully implemented and enrollment is fully mature in 2011. Estimates assume that the exchange is open to individuals and firms with fewer than 50 workers only.
Source: The Lewin Group using the Health Benefits Simulation Model (HBSM).

We estimate that the number of people purchasing coverage as individuals in the individual market would increase from 14.3 million people under current law to about 31.4 million people once the act is fully implemented. Of these about 24.9 million (70 percent) people would obtain their coverage through the exchange. This reflects that the premiums subsidy tax credit is available only to individuals purchasing coverage through the exchange.

We estimate that the number of people with private employer-sponsored insurance (ESI) would decline by about 7.3 million people under the Act. These include 19.1 million workers and dependents that would lose their employer coverage, primarily in cases where the employer decides to discontinue their employer health plan once the expanded Medicaid and premium subsidy programs become available. However, this loss of employer coverage is partly offset by increased employer coverage of 11.8 million people in cases where the employer decides to start offering coverage to avoid the new employer penalty payments.

The discontinuations of employer coverage are known as "crowd-out." Because subsidies are available only for people purchasing individual coverage through the exchange, some insuring firms would find that workers can obtain individual coverage with the subsidies for less than it would cost to continue with their employer plan. Some employees may also become covered under the expanded Medicaid program. This would affect many employers since subsidies are available through 400 percent of the FPL, which is about $88,000 for a family of four. These firms are the ones most likely to discontinue coverage.

*Figure 5* presents a detailed summary of the changes in sources of coverage under the Act.

Figure 5
## Transitions in Coverage under the America's Healthy Future Act of 2009; Assuming Full Implementation in 2011 (thousands)[a]

| Coverage Under Current Law | | Coverage Through Exchange | | Private Coverage | | | TRICARE | Medicare | Medicare & Medicaid Dual Eligible | Medicaid and SCHIP | Uninsured |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Employer | Individual | Employer | Individual | Retiree | | | | | |
| Employer Workers and Dependents | 154,436 | 5,933 | 12,257 | 129,363 | 0 | 0 | 0 | 0 | 0 | 3,923 | 2,960 |
| Private Non-Employer | 14,335 | 377 | 4,112 | 1,715 | 6,532 | 0 | 0 | 0 | 0 | 763 | 836 |
| Employer Retiree | 3,711 | 0 | 0 | 0 | 0 | 3,711 | 0 | 0 | 0 | 0 | 0 |
| TRICARE | 6,142 | 0 | 0 | 0 | 0 | 0 | 6,142 | 0 | 0 | 0 | 0 |
| Medicare | 33,195 | 0 | 0 | 0 | 0 | 0 | 0 | 33,195 | 0 | 0 | 0 |
| Medicare & Medicaid Dual Eligible | 6,811 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6,811 | 0 | 0 |
| Medicaid and SCHIP | 41,673 | 528 | 524 | 996 | 0 | 0 | 0 | 0 | 0 | 39,625 | 0 |
| Uninsured | 49,191 | 2,161 | 7,979 | 6,022 | 0 | 0 | 0 | 0 | 0 | 11,510 | 21,519 |
| Total | 309,494 | 8,999 | 24,872 | 138,096 | 6,532 | 3,711 | 6,142 | 33,195 | 6,811 | 55,821 | 25,315 |

a/ For illustrative purposes, we assume that the program is fully implemented and enrollment is fully mature in 2011.
Source: The Lewin Group Estimates using the Health Benefits Simulation Model (HBSM).

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495261

As discussed above, we estimate that about 25.3 million people would remain uninsured under the Act. Of these 19.4 million are people who are exempt from the penalty for those who remain uninsured (*Figure 6*). Of these, abut 4.0 million are undocumented immigrants. These also include about 4.7 million adults living below 133 percent of the FPL, and 2.0 million adults who were uninsured for 3 months or less, both of which groups are specifically exempted from the Penalty. Another 3.8 million are children, who are also exempt from the penalty under the Act. There also would be about 5.0 million adults that are also exempt from the penalty because the coverage available to them would cost more than 8 percent of their income.

### Figure 6
### Number of People Remaining Uninsured under the Act if Fully Implemented in 2011
### (millions)

|  | Number Remaining Uninsured |
|---|---|
| **Undocumented Immigrants** | 4.0 |
| **Exempt from Penalty** |  |
| Children | 3.7 |
| Adults below 133 Percent of FPL | 4.7 |
| Uninsured 3 Months or Less | 2.0 |
| Premiums over 8 Percent of Income | 5.0 |
| **Total Exempt from the Penalty** | **15.4** |
| **Subject to Penalty** |  |
| Pay Penalty | 4.3 |
| Do not Pay Penalty | 1.6 |
| **Total Subject to Penalty** | **5.9** |
| **Total Remaining Uninsured** | **25.3** |

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

About 5.9 million of the uninsured would be adults that face a penalty for not having insurance. However, we estimate that only 4.3 million of these people would pay the penalty. About 1.6 million people would not voluntarily pay the penalty because they do not file a tax return.[3]

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[3]  There are estimated to be about 12 million undocumented people in the U.S. We assume that of these, 6.2 million are uninsured.

495261

## C. Impact on Federal Spending

In this study, we developed estimates of the impact of the Act on federal spending over a 20 year period between 2010 through 2029. The Congress uses 10-year forecasts for budgeting purposes, which is currently 2010 through 2019. Because the coverage expansions under the Act would not take effect until 2013, the program would be in operation for only 7 of the 10 years included in the 10-year "budget window." To better understand the long-term budget implications of the Act, we present spending estimates for both the 2010 through 2019 budget window and the 2020 through 2029 period.

New federal spending under the Act would be $875.3 billion over the 2010 through 2019 period (*Figure 7*). This would be offset by $291.0 billion resulting from the coverage provisions of the proposal, including individual and employer penalties. It also includes $240.5 billion in revenues from the excise tax on high-cost health plans. The financing provisions of the Act include $404.2 billion in spending reductions for Medicare and Medicaid, and other new tax revenues of about $196.0 billion.

This results in a net reduction in the federal deficit of $15.9 billion over this 10-year period. We also project continuing deficit reductions totaling $371.3 billion over the 2020 through 2029 period. As discussed below, the primary reason for this is that the thresholds for the excise tax on high-cost plans are indexed at about half of the rate of growth in health care costs over-time, resulting in a steady increase in the number of plans affected.

### 1. New Program Spending

Key elements of new federal spending under the Act include:

- **Medicaid expansion:** Income eligibility levels for parents with custodial responsibilities for children would be increased to 133 percent of the FPL in all states. Non-custodial adults also would be eligible in all states through 133 percent of the FPL. Overall, the federal government would cover about 90 percent of the cost of these Medicaid expansions;

- **Premium tax credits:** The Act would provide premium and cost-sharing subsidies for private insurance sold through the exchange on a sliding scale with income for people who do not have access to affordable ESI. Workers offered coverage by an employer are not eligible unless the employer coverage would cost the worker more than 10 percent of his/her income;

- **Small employer tax credit:** The Act includes a tax credit for employers with fewer than 25 fulltime equivalent (FTE) workers for up to half of the employer cost of coverage. As discussed above, the tax credit is phased-out for employers with average payroll between $20,000 and $40,000. The credit is also phased-out for firms with between 10 and 25 workers. The credit is available to any given employer for no more than 2 years; and

## Figure 7
## Changes in Federal Expenditures and Revenues the America's Healthy Future Act of 2009: 2010-2029
### (billions)

| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2010-2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Public Program Costs** | | | | | | | | | | | |
| Medicaid Eligibility Expansion | -$0.2 | -$0.2 | -$0.3 | -$2.7 | $18.1 | $49.5 | $59.5 | $63.9 | $68.6 | $73.2 | $329.4 |
| Premium Subsidies | $0.0 | $0.0 | $0.0 | $25.0 | $60.3 | $72.1 | $77.6 | $83.7 | $90.1 | $97.0 | $505.7 |
| Employer Tax Credit | $0.0 | $2.5 | $3.3 | $5.5 | $4.4 | $2.0 | $2.2 | $2.3 | $2.4 | $2.6 | $27.2 |
| Retiree Reinsurance Program | $0.0 | $0.0 | $0.0 | $1.5 | $1.7 | $1.8 | $0.0 | $0.0 | $0.0 | $0.0 | $5.0 |
| High Risk Pool/Co-Op Funding | $1.0 | $2.0 | $2.0 | $1.5 | $1.5 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $8.0 |
| Total Program Costs | $0.8 | $4.3 | $5.0 | $30.8 | $85.9 | $125.4 | $139.3 | $149.9 | $161.1 | $172.8 | $875.3 |
| **Program Offsets** | | | | | | | | | | | |
| Employer Pay-or-Play Taxes | $0.0 | $0.0 | $0.0 | $5.1 | $8.4 | $9.3 | $9.7 | $10.2 | $10.7 | $11.3 | $64.8 |
| Penalties for Uninsured | $0.0 | $0.0 | $0.0 | $0.0 | $0.9 | $1.9 | $3.0 | $3.8 | $3.9 | $4.0 | $17.6 |
| Federal Worker Health Benefits | $0.0 | $0.0 | $0.0 | $0.0 | -$1.1 | -$2.6 | -$3.2 | -$3.6 | -$4.0 | -$4.5 | -$18.9 |
| Taxes on Changes in Wages | -$0.9 | -$0.7 | -$0.7 | $1.4 | $1.7 | -$0.7 | -$1.7 | -$2.6 | -$3.7 | -$5.0 | -$12.9 |
| Tax on High cost Insurance | $0.0 | $0.0 | $0.0 | $12.1 | $23.0 | $28.6 | $33.8 | $40.0 | $47.3 | $55.9 | $240.5 |
| Total Offsets | -$0.9 | -$0.7 | -$0.7 | $18.6 | $33.0 | $36.5 | $41.6 | $47.8 | $54.2 | $61.6 | $291.0 |
| | | | | | | | | | | | |
| Net Federal Cost | $1.7 | $5.0 | $5.7 | $12.2 | $53.0 | $89.0 | $97.7 | $102.1 | $106.9 | $111.1 | $584.3 |
| | | | | | | | | | | | |
| Medicare and Medicaid Payment Reforms [a] | $9.0 | -$0.6 | -$10.9 | -$21.0 | -$41.7 | -$46.7 | -$54.7 | -$66.0 | -$78.1 | -$93.5 | -$404.2 |
| | | | | | | | | | | | |
| Other Revenue Measures [b] | $11.1 | $13.4 | $14.4 | $19.0 | $20.1 | $20.9 | $22.0 | $23.8 | $25.3 | $26.0 | $196.0 |
| | | | | | | | | | | | |
| Net Federal Cost of Reform | -$0.4 | -$9.0 | -$19.6 | -$27.8 | -$8.8 | $21.4 | $21.0 | $12.3 | $3.5 | -$8.4 | -$15.9 |

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Figure 7 (continued)
## Changes in Federal Expenditures and Revenues under the America's Healthy Future Act of 2009: 2019-2029
### (billions)

| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2020-2029 | 2010-2029 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Public Program Costs** | | | | | | | | | | | | |
| Medicaid Eligibility Expansion | $78.8 | $84.8 | $91.4 | $98.4 | $105.9 | $114.1 | $122.8 | $132.3 | $142.4 | $153.4 | $1,124.4 | $1,453.7 |
| Premium Subsidies | $104.5 | $112.5 | $121.1 | $130.4 | $140.5 | $151.3 | $162.9 | $175.4 | $188.9 | $203.4 | $1,490.7 | $1,996.5 |
| Employer Tax Credit | $2.7 | $2.9 | $3.1 | $3.3 | $3.5 | $3.7 | $3.9 | $4.1 | $4.4 | $4.7 | $36.3 | $63.5 |
| Retiree Reinsurance Program | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $5.0 |
| High Risk Pool/Co-Op Funding | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $8.0 |
| Total Program Costs | $186.0 | $200.2 | $215.6 | $232.1 | $249.9 | $269.0 | $289.6 | $311.8 | $335.7 | $361.4 | $2,651.4 | $3,526.7 |
| **Program Offsets** | | | | | | | | | | | | |
| Employer Pay-or-Play Taxes | $11.8 | $12.4 | $13.0 | $13.7 | $14.4 | $15.1 | $15.9 | $16.7 | $17.6 | $18.5 | $149.2 | $214.0 |
| Penalties for Uninsured | $4.1 | $4.3 | $4.4 | $4.5 | $4.7 | $4.8 | $5.0 | $5.1 | $5.3 | $5.4 | $47.6 | $65.1 |
| Federal Worker Health Benefits | -$4.9 | -$5.4 | -$5.9 | -$6.5 | -$7.2 | -$7.9 | -$8.7 | -$9.5 | -$10.4 | -$11.4 | -$77.9 | -$96.9 |
| Taxes on Changes in Wages | -$6.0 | -$7.1 | -$8.5 | -$10.0 | -$11.9 | -$13.7 | -$15.8 | -$18.2 | -$20.9 | -$23.8 | -$135.9 | -$148.9 |
| Tax on High cost Insurance | $64.9 | $75.3 | $87.5 | $101.6 | $118.0 | $134.5 | $153.4 | $174.8 | $199.3 | $227.2 | $1,336.6 | $1,577.1 |
| Total Offsets | $70.0 | $79.5 | $90.6 | $103.3 | $118.0 | $132.8 | $149.7 | $168.9 | $190.8 | $215.8 | $1,319.4 | $1,610.4 |
| | | | | | | | | | | | | |
| Net Federal Cost | $116.0 | $120.7 | $125.0 | $128.8 | $131.9 | $136.2 | $139.9 | $142.9 | $144.9 | $145.6 | $1,332.0 | $1,916.3 |
| | | | | | | | | | | | | |
| Medicare and Medicaid Payment Reforms [a] | -$100.3 | -$108.0 | -$116.2 | -$124.8 | -$133.8 | -$143.1 | -$152.4 | -$161.5 | -$169.8 | -$176.2 | -$1,386.1 | -$1,790.3 |
| | | | | | | | | | | | | |
| Other Revenue Measures [a] | $26.6 | $27.3 | $28.0 | $28.7 | $29.5 | $30.4 | $31.2 | $32.2 | $33.1 | $34.2 | $301.3 | $497.3 |
| | | | | | | | | | | | | |
| Net Federal Cost of Reform | -$10.9 | -$14.6 | -$19.1 | -$24.8 | -$31.5 | -$37.3 | -$43.7 | -$50.8 | -$58.0 | -$64.8 | -$355.4 | -$371.3 |

a/ These estimates are based upon: Congressional Budget Office, Letter to the Honorable Max Baucus, Chairman, Committee on Finance, U.S. Senate, from Douglas W. Elmendorf, Director, The Congressional Budget Office, October 7, 2009.
Source: The Lewin Group using the Health Benefits Simulation Model (HBSM).

495261

- **Reinsurance program:** The Bill allocates $5.0 billion to provide reinsurance for high-cost early retirees currently covered under employer health plans. Under the reinsurance coverage provisions of the act, we estimate that the funds would be exhausted by the third year of its availability.

The Act provides about $875.3 billion in new benefits over the 2010 through 2019 period. These include increased Medicaid spending of $329.4 billion and premium and cost sharing subsidies of $505.7 billion. The employer tax credit would cost $27.2 billion over the 2010 through 2019 period. Total benefits costs over the following 10-year period (i.e., 2020 through 2029) would be $2.65 trillion. In addition, federal health benefits costs for federal workers would increase by about 11.4 million over this period due to the excise tax and the costs of coverage or paying penalties for uninsured workers.

The Medicaid coverage expansions would begin in 2014. We expect the program to reach full enrollment by 2017 as newly eligible people learn of their eligibility. Our long term budget estimates reflect the timing of these events. However, for illustrative purposes, we present our estimates of the effect of these changes assuming the program is fully implemented and enrollment is fully mature in 2011 (*Figure 8*).

### Figure 8
### Changes in Medicaid Enrollment and Costs under the America's Healthy Future Act, assuming it is fully implemented in 2011[a/]

| | Changes in Medicaid and CHIP Enrollment (in 1,000s) | Changes in Medicaid and CHIP Spending (billions) | | |
| --- | --- | --- | --- | --- |
| | | Total | Federal | State |
| **Current Enrollment and Cost** | 48,484 | $452.0 | $255.2 | $196.8 |
| **Changes in Enrollment and Costs Under the Bill** | | | | |
| Current Enrollees Shifting to Private Coverage | -1,524 | -$6.2 | -$3.6 | -$2.6 |
| Current Enrollees losing coverage due to elimination of income disregards | -524 | -$2.2 | -$1.3 | -$0.9 |
| **Enrollment Increases for Currently Eligible** | | | | |
| Children | 1,537 | $1.5 | $0.9 | $0.6 |
| Adults | 904 | $2.7 | $1.6 | $1.1 |
| Total currently Eligible | 2,441 | $4.2 | $2.4 | $1.8 |
| **Eligibility Expansions** | | | | |
| Parents | 2,561 | $7.0 | $6.4 | $0.6 |
| Non-Custodial Adults | 11,194 | $41.7 | $38.2 | $3.5 |
| Total Newly Eligible | 13,755 | $48.7 | $44.7 | $4.0 |
| **Net Change** | 14,148 | $44.5 | $42.3 | $2.2 |

a/ For illustrative purposes, this scenario assumes that the Act is fully implemented and enrollment is fully matured in 2011.
Source: The Lewin Group using the Health Benefits Simulation Model (HBSM).

We estimate that there will be about 48.5 million people enrolled in Medicaid (average monthly/point in time enrollment) in 2011 on an average monthly basis (excludes people in

nursing homes). About 1.5 million of these enrollees would be workers in firms that decide to offer coverage in response to the penalties under the Act. Another 524,000 people would lose coverage when the use of income disregards in determining eligibility is terminated. Most of these individuals would qualify for the premium tax credit, unless their employer offers coverage.

We estimate that about 2.4 million people who are currently eligible but not enrolled would be induced to enroll as a result of outreach under the Act. About 1.5 million of these new enrollees would be children eligible under the existing Medicaid or the CHIP programs. Another 13.8 million people would become covered under the expansions in eligibility for adults

## 2. Spending Offsets for New Programs

Total program offsets over the 2010 through 2019 period would be $291.0 billon, of which $240.5 billion would be due to the excise tax on high-cost health plans (discussed below).

These offsets include penalties paid by non-insuring employers for workers receiving the tax credit for coverage they purchase through the exchange. As described above, the program would require employers who do not provide health insurance to pay a penalty of up to $400 per fulltime worker they do not cover. Total employer penalty revenues would be $64.8 billion over the 2010 through 2019 period.

We also project $17.6 billion in penalty revenues for people who go without insurance over the 2010 through 2019 period. The penalty amount would be $750 per uninsured adult, which is phased-in between 2014 through 2017. Uninsured people are exempt from the penalty if the lowest cost coverage option available to them exceeds 8 percent of income.

However, the program would result in a loss of income and payroll tax revenues of $12.9 billion over the 2010 through 2019 period. This revenue loss is due to slowed wage growth resulting from the increase in employer costs under the Act. As discussed below, we estimate that the employer health spending would initially decline under the Act, but would increase after 2015, largely due to the excise taxes under the bill. The available research indicates that employers would pass on these higher costs to workers in the form of reduced wage growth, resulting in an associated loss of federal income and payroll tax revenues.

Total offset over the 2020 through 2029 period would be $1.32 trillion. Total benefits costs ($2.65 trillion) less offsets over that period would be $1.33 trillion.

## 3. Excise Tax on High-cost Health Plans

As discussed above, the Act creates a new excise tax on high-cost insurance plans. Insurers would pay a tax equal to 40 percent of the amount by which premiums for an employer health plan exceeds $8,000 for individuals and $21,000 for families beginning in 2013. (Higher thresholds apply to workers in high-risk occupations and retirees age 55 to 64.) Insures pay the excise tax based upon data provider by the employer.

These thresholds are indexed each year by the Consumer Price Index (CPI) plus one percentage point. Because health care costs are expected to grow at nearly twice that rate, more and more

health plans will become subject to the tax for increasing amounts over time. As a consequence, the amount of revenues raised by the tax will grow by over 15 percent per year. As shown in *Figure 9*, we estimate that in 2013, there will be about 33.3 million people (workers dependents and retirees) in firms with benefits costs that exceed the high-cost thresholds, including 3.1 million retirees. The number of people in affected firms would grow to 60.5 million people by 2019 and 110.7 million people by 2029.

### Figure 9
### Number of People with Policies subject to the Excise Tax on High-Cost Health Plan Thresholds (millions)[a]
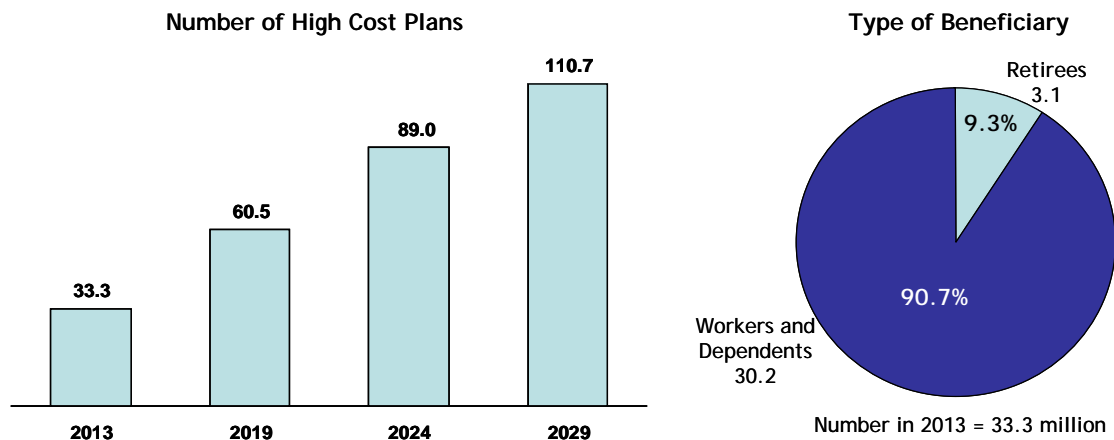


a/ The threshold amounts are $8,000 for individuals and $21,000 for families in 2013. These amounts are indexed annually to the CPI Plus 1.0 percent.
Source: The Lewin Group using the Health Benefits Simulation Model (HBSM).

We estimate that the tax would raise revenues of about $240.5 billion over the 2010 through 2019 period, and $1.34 trillion over the 2020 through 2029 period. In fact, the growth in revenues from the tax would exceed the growth in new federal health benefits costs over this period, which is the primary reason we show the Act to be better than fully funded through 2029.

### 4. Other Financing Measures

The program is funded with reductions in spending under the Medicare and Medicaid programs, that the CBO and the JCT estimate would save $404.2 billion over the 2010 through 2019 period. It would impose a second excise tax on insurers (fully insured only) and creates additional excise taxes on manufacturers and importers on branded prescription drugs and medical devices. Total revenues from these excise taxes would be $120.8 billion over that period. The plan includes an additional $75.2 billion in revenues from other changes in tax provisions and revenue effects.

We estimate that these changes in program spending and revenues would continue through the next decade. Savings to Medicare and Medicaid would be $1.39 trillion over the 2020 through 2029 period. New revenues would total $301.3 billion over that same period.

We estimated these amounts by extending the 10-year estimates for 2010 through 2019 provided by CBO and the JCT through 2029 on a line-item basis. In most instances, we simply assumed

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495261

that the savings amounts for Medicare and Medicaid would grow in proportion to program growth as projected by the Office of the Actuary of the CMS and as reported in the Medicare trustees report. The Act sets these excise tax rates at the levels required to collect a fixed dollar amount of revenues, which we assume continues through the next decade as well. Other tax provisions were projected to increase with health spending as projected by the actuaries of the CMS.

### 5. Net Federal Costs

Total federal spending for health will be $39.5 trillion over the twenty-year period between 2010 and 2029 (*Figure 10*). This includes all spending for health services and supplies by all payers including governments, insurers and consumers. About 56 percent of that spending would be for the Medicare program (net of premium offsets). Yet the Medicare trust fund is expected to be exhausted by 2017. Thus it is important to consider the long-term effects of the program on the federal deficit.

Figure 10
Federal Spending for Health under Current Law and Changes in Spending under the America's
Healthy Future Act of 2009

| | Federal Spending Under Current Law (billions) | | | | | | Change in Net Federal Spending Under Act | |
|---|---|---|---|---|---|---|---|---|
| | Medicare | Medicare Premiums | Medicaid | Other Federal | Federal Workers | Total Federal | Amount (billions) | Percent Change |
| 2010 | $516 | -$41 | $237 | $116 | $30 | $857 | -$0.4 | 0.0% |
| 2011 | $547 | -$44 | $255 | $124 | $31 | $913 | -$9.0 | -1.0% |
| 2012 | $585 | -$44 | $275 | $132 | $33 | $981 | -$19.6 | -2.0% |
| 2013 | $628 | -$49 | $297 | $142 | $34 | $1,053 | -$27.8 | -2.6% |
| 2014 | $674 | -$48 | $322 | $152 | $36 | $1,137 | -$8.8 | -0.8% |
| 2015 | $729 | -$50 | $350 | $163 | $39 | $1,231 | $21.4 | 1.7% |
| 2016 | $789 | -$54 | $381 | $175 | $41 | $1,332 | $21.0 | 1.6% |
| 2017 | $858 | -$58 | $414 | $187 | $43 | $1,444 | $12.3 | 0.8% |
| 2018 | $932 | -$63 | $451 | $200 | $46 | $1,566 | $3.5 | 0.2% |
| 2019 | $1,012 | -$65 | $491 | $214 | $49 | $1,701 | -$8.4 | -0.5% |
| 2020 | $1,100 | -$72 | $534 | $229 | $52 | $1,844 | -$10.9 | -0.6% |
| 2021 | $1,195 | -$78 | $581 | $246 | $55 | $1,999 | -$14.6 | -0.7% |
| 2022 | $1,299 | -$86 | $633 | $263 | $59 | $2,167 | -$19.1 | -0.9% |
| 2023 | $1,411 | -$94 | $689 | $281 | $62 | $2,349 | -$24.8 | -1.1% |
| 2024 | $1,533 | -$103 | $750 | $301 | $66 | $2,547 | -$31.5 | -1.2% |
| 2025 | $1,665 | -$113 | $817 | $322 | $70 | $2,761 | -$37.3 | -1.3% |
| 2026 | $1,809 | -$123 | $889 | $345 | $74 | $2,994 | -$43.7 | -1.5% |
| 2027 | $1,966 | -$135 | $968 | $369 | $79 | $3,247 | -$50.8 | -1.6% |
| 2028 | $2,136 | -$147 | $1,054 | $395 | $84 | $3,521 | -$58.0 | -1.6% |
| 2029 | $2,321 | -$160 | $1,147 | $423 | $89 | $3,819 | -$64.8 | -1.7% |
| 2010-2019 | $7,271 | -$518 | $3,473 | $1,605 | $383 | $12,214 | -$15.9 | -0.1% |
| 2020-2029 | $16,435 | -$1,111 | $8,063 | $3,173 | $689 | $27,248 | -$355.4 | -1.3% |
| 2010-2029 | $23,705 | -$1,629 | $11,536 | $4,779 | $1,072 | $39,463 | -$371.3 | -0.9% |

Source: Lewin Group estimates using Health Spending Projections developed by the Office of the Actuary (OAct) of the Centers for Medicare and Medicaid Services (CMS).

We estimate that the Act would reduce the federal deficit by $371.3 billion over that 20 year period. Deficit reduction would be $15.9 over the 2010 through 2019 period and $355.4 billion over the following decade. These savings represent a net reduction in total national health spending (i.e., all payers) of roughly one percent over the 20-year period.

## 6. Program Savings and Long-term Budget Effects

Funding for the proposal is critically dependent upon the proposed savings to Medicare and Medicaid included in the Act. As discussed above, the CBO estimates that these provisions would save about $404.2 billion over the 2010 through 2019 period. We estimate that these savings would increase with projected program growth over the 2020 through 2029 period and would reach $1.39 trillion over the 2020 through 2029 period.

Of the $404.2 billion in savings over the 2010 through 2019 period, about $264.7 billion is attributed to reductions in the rate of growth in payments to providers for health services, plus reductions in hospital DSH payments. Congress is certain to hear many appeals from providers to restore some of these budget cuts in future years. For example, Congress eventually restored many of the cuts in provider reimbursement that they adopted under the Balanced Budget Act of 1997. Congress also initiated cuts in reimbursement to physicians under the Sustainable Growth Rate (SGR) provisions, which are routinely overridden each year by the Congress.

To illustrate the importance of maintaining these reimbursement reductions on the long-term financial stability of the program, we developed estimates of the net impact of the Act on the federal deficit under alternative scenarios. As shown in (*Figure 11*), we estimate that the Act as proposed would reduce the federal deficit by about $371.3 billion over the 20-year period between 2010 through 2029. If these reductions in reimbursement were to be reduced by 25 percent, the program would still reduce the deficit over this 20-year period by $96.5 billion, although it would run a deficit of $41.3 billion over the 2010 through 2019 period.

If only half of these payment reductions are sustained, the program would result in a deficit of $107.4 billion over the 2010 through 2019 period, and $109.7 billion over the following decade. A 75 percent reduction in these provider cuts would result in a deficit of $173.5 billion under the Act over the 2010 through 2019 period, and a deficit of $357.2 billion over the following ten years.

Figure 11
Estimated Impact of the Act on the Federal Deficit under Alternative Provider Payment
Assumptions 2010 to 2029

| | Net Impact of the Act on the Deficit | | |
| --- | --- | --- | --- |
| | 2010-2019 | 2020-2029 | 2010-2029 |
| Proposed Medicare and Medicaid Savings under the Act | -$15.9 | -$355.4 | -$371.3 |
| **Alternative Scenarios** | | | |
| Provider Payment Cuts reduced by 25 percent | $41.3 | -$137.8 | -$96.5 |
| Provider Payment Cuts reduced by 50 percent | $107.4 | $109.7 | $217.1 |
| Provider Payment Cuts reduced by 75% | $173.5 | $357.2 | $530.7 |

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

## D. Impact on State and Local Governments

The Act would result in savings to state and local governments of about $63.7 billion over the 2010 through 2019 period (*Figure 12*). State and local governments would save $122.2 billion on spending for safety-net programs such as public hospitals and clinics. However these savings would be partly offset with increases in spending for other state benefits programs, including worker health benefits costs.

The Medicaid expansions under the Act would increase state spending for Medicaid by $14.4 billion over the 2010 through 2019 period. This includes the state share of the cost of covering newly eligible people (roughly 10 percent). It also reflects reductions in enrollment for people who become covered under an employer plan, and those who leave the program as income disregards are eliminated.

State spending for employee health benefits would increase by $45.4 billion under the Act. This reflects the cost of covering state and local workers who do not now have coverage and/or the cost of the penalty for uninsured workers. It also reflects the impact of the various excise taxes on the cost of health benefits for workers and retirees.

The primary source of savings for state and local governments would be attributed to safety-net programs that provide funding to providers such as free clinics and public hospitals. Due to the expansion in insurance coverage, safety-net providers would be reimbursed for the services that under current law they would have provided free to the uninsured. Thus, these providers would see an increase in net income, which could be used either to provide additional services or reduce state and local funding for these providers.

Some states also sponsor subsidized insurance programs for low-income people who are not eligible for Medicaid under federal rules. These programs would be largely superseded by the expanded Medicaid program and the new premium subsidy program under the Act, resulting in savings to these state and local governments. Alternatively, the Act permits states to continue operation of existing health benefits programs such as the "Basic Health Plan" in Washington.

State and local governments would generally see net savings through the 2020 through 2029 period as well.

# Figure 12
## Changes in Spending and Revenues for State and Local Governments under the America's Healthy Future Act of 2009: 2010 – 2029
### (billions)

| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2010-2019 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Spending under Current Law | $445.3 | $472.5 | $501.3 | $533.5 | $569.4 | $609.3 | $652.5 | $699.6 | $750.5 | $805.2 | $6,039.1 | |
| Medicaid and CHIP Programs | -$0.2 | -$0.2 | -$0.2 | -$2.1 | -$1.2 | $2.0 | $3.2 | $3.6 | $4.2 | $5.2 | $14.4 | |
| Savings to Current Safety-net programs | $0.0 | $0.0 | $0.0 | -$9.6 | -$6.9 | -$16.6 | -$19.9 | -$21.4 | -$23.1 | -$24.8 | -$122.2 | |
| State and Local Government Worker Health Benefits Programs | $1.0 | $1.7 | $2.4 | $2.8 | $3.5 | $4.0 | $5.6 | $6.7 | $8.0 | $9.7 | $45.4 | |
| Tax Revenues From Wage Effects (Counted as Offset) | -$0.1 | -$0.1 | -$0.1 | $0.1 | $0.2 | -$0.1 | -$0.2 | -$0.3 | -$0.4 | -$0.5 | -$1.3 | |
| Net Impact on State and Local Governments | $0.7 | $1.5 | $2.1 | -$8.8 | -$4.4 | -$10.6 | -$11.3 | -$11.3 | -$11.2 | -$10.5 | -$63.7 | |
| Percent Change in Spending | 0.2% | 0.3% | 0.4% | -1.6% | -0.8% | -1.7% | -1.7% | -1.6% | -1.5% | -1.3% | -1.1% | |
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2020-2029 | 2010-2029 |
| Spending Under Current Law | $864.2 | $927.7 | $996.0 | $1,069.6 | $1,148.9 | $1,234.3 | $1,326.3 | $1,425.5 | $1,532.5 | $1,647.8 | $12,172.8 | $18,211.9 |
| Medicaid and CHIP Programs | $5.6 | $6.0 | $6.5 | $7.0 | $7.5 | $8.1 | $8.7 | $9.4 | $10.1 | $10.8 | $79.5 | $93.9 |
| Savings to Current Safety-net Programs | -$26.7 | -$28.8 | -$31.0 | -$33.4 | -$35.9 | -$38.7 | -$41.7 | -$44.9 | -$48.3 | -$52.0 | -$381.5 | -$503.7 |
| State and Local Government Worker Health Benefits Programs | $10.8 | $12.2 | $13.7 | $15.5 | $17.6 | $19.6 | $21.9 | $24.4 | $27.2 | $30.3 | $193.2 | $238.6 |
| Tax Revenues From Wage Effects (Counted As Offset) | -$0.6 | -$0.7 | -$0.8 | -$1.0 | -$1.2 | -$1.3 | -$1.5 | -$1.8 | -$2.0 | -$2.3 | -$13.2 | -$14.4 |
| Net Impact on State and Local Governments | -$10.9 | -$11.3 | -$11.6 | -$11.9 | -$12.0 | -$12.4 | -$12.6 | -$12.9 | -$13.1 | -$13.2 | -$121.9 | -$185.6 |
| Percent Change in Spending | -1.3% | -1.2% | -1.2% | -1.1% | -1.0% | -1.0% | -1.0% | -0.9% | -0.9% | -0.8% | -1.0% | -1.0% |

Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM)

495261

## D. Private Employer Impacts

The Act includes features that would encourage employers to offer coverage. For example, the Act includes a tax credit for small employers who offer coverage. Firms with over 50 workers also face a penalty of up to $400 per fulltime worker for uninsured workers who receive a premium tax credit through the exchange. In addition, the mandate for all Americans to have coverage is likely to increase worker demand for employer coverage, which often can be provided at a lower cost by employer groups.

However, the availability of the expanded Medicaid program and premium subsidies for lower-wage workers could cause some employers to discontinue coverage. This is particularly true of low-wage employers where workers can obtain publicly subsidized coverage for less than it costs the employer to provide the same coverage. In fact, as discussed above, we estimate that there would be a net reduction in the number of workers and dependents with employer provided health insurance of 7.3 million people once fully implemented.

### 1. Employer Health Spending

Total spending for private ESI will be about $452.4 billion in 2011 (*Figure 13*). This includes the value of the employer share of the cost of health insurance among private employers.[4] Spending for workers and dependents will be $423.6 billion while spending for retiree health benefits will be about $28.8 billion.

Spending for currently insuring firms would decline by $23.0 billion under the Act, assuming it is fully implemented in 2011. Employer premium payments would decline by about $42.2 billion, reflecting our estimate that about 19.1 million workers and dependents would be in plans where employers would eliminate their coverage under the Act. This reflects the "crowd-out" expected as subsidized coverage under Medicaid and the exchange becomes available. Employer penalty payments for uninsured workers receiving a premium credit in the exchange would be $8.0 billion.

Currently insuring firms would also receive about $4.0 billion under the small employer tax credit. These credits would last for two years only.

As discussed above, we assume that most of the cost of the new excise taxes is passed back to employers and consumers in the form of higher premiums. In 2011, this would add $13.4 billion to premiums for private firms that continue to offer coverage. The reductions in payments for provider services under Medicare and Medicaid would result in increases cost-shifting, which would increase the cost shift to currently insured firms by about $1.6 billion in that year.

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[4] The impact on health benefits costs for government employees is incorporated into our public spending estimates presented above.

Figure 13
**Change in Private Employer Health Benefit Costs by Current
Insuring Status under the America's Healthy Future Act for 2011 (billions)** [a/]

| | All Firms Eligible for Exchange | | |
|---|---|---|---|
| | Currently Insuring Employer | Currently Non-Insuring Employer | All Employers |
| **Private Employer Spending under Current Law** | | | |
| Current Cost of Coverage | | | |
|    Workers and Dependents | $423.6 | $0.0 | $423.6 |
|    Retirees | $28.8 | $0.0 | $28.8 |
| **Total Current Law** | **$452.4** | **$0.0** | **$452.4** |
| **Private Employer Health Spending under the Act** | | | |
| Premiums for Employers | $381.4 | $9.1 | $390.5 |
| Impact of Excise Tax on High Cost Premiums | $7.6 | $0.1 | $7.4 |
| Impact of other Excise Taxes | $6.3 | $0.1 | $6.2 |
| Costs for Retirees | $28.5 | $0.0 | $28.5 |
| Change in Cost Shift | $1.6 | $0.0 | $2.1 |
| Small Employer Tax Credit | -$4.0 | -$1.0 | -$5.0 |
| Penalty for Uninsured Workers | $8.0 | $0.9 | $8.9 |
| **Total Spending Under The Policy** | **$429.4** | **$9.2** | **$438.6** |
| **Net Change in Private Employer Spending** | | | |
| **Net Change** | **-$23.0** | **$9.2** | **-$13.8** |

a/ For illustrative purposes, this scenario Assumes that the Act is fully implemented and
enrollment is fully matured in 2011.
Source: Lewin Group Estimates Using the Health Benefits Simulation Model (HBSM)

Firms that currently do not offer coverage to any of their employees would see an increase in
spending of $9.2 billion. However, nearly all of this would be attributed to firms that decide to
offer coverage rather than pay the penalty. These firms would pay only about $0.9 billion in
penalty payments, reflecting that many workers in non-insuring firms already have coverage as
a dependent of a spouse with employer coverage or from other sources such as Medicare. Small
firms that start to offer coverage would receive about $1.0 billion through the small employer
tax credit.

### 2. Long-Term Impact on Private Employer Spending

Total health spending for private employers nationwide would fall by about 3.3 percent once
fully implemented in 2014, largely due to discontinuations of coverage. But employer cost
under the Act would increase above current spending levels after 2016. Private employer health
spending would actually decline by about $19.9 billion over the 2010 through 2019 period
(*Figure 14*).

Figure 14
Changes in Private Employer Health Spending under the America's Healthy Future Act of 2009

| | Spending under Current Law | Change in Spending under the Act | | | | Percent Change in Total Spending under the Act |
|---|---|---|---|---|---|---|
| | | Excise Taxes in Premiums | Cost Shifting | Coverage and Penalty Provisions | Total Change in Spending under the Act | |
| 2010 | $433.3 | $5.5 | -$1.7 | $0.7 | $4.4 | 1.0% |
| 2011 | $453.8 | $6.1 | -$1.2 | -$2.6 | $2.2 | 0.5% |
| 2012 | $474.8 | $6.3 | $0.6 | -$5.3 | $1.5 | 0.3% |
| 2013 | $498.2 | $13.7 | $0.0 | -$27.3 | -$13.6 | -2.7% |
| 2014 | $525.5 | $18.5 | $1.6 | -$37.2 | -$17.1 | -3.3% |
| 2015 | $555.9 | $21.3 | $1.7 | -$28.6 | -$5.7 | -1.0% |
| 2016 | $588.5 | $23.9 | $2.3 | -$28.9 | -$2.8 | -0.5% |
| 2017 | $623.7 | $27.0 | $3.2 | -$30.4 | -$0.1 | 0.0% |
| 2018 | $660.7 | $30.7 | $4.3 | -$31.7 | $3.3 | 0.5% |
| 2019 | $700.0 | $35.0 | $6.0 | -$33.2 | $7.9 | 1.1% |
| 2020 | $741.5 | $39.6 | $6.5 | -$34.7 | $11.3 | 1.5% |
| 2021 | $785.6 | $44.8 | $7.0 | -$36.3 | $15.5 | 2.0% |
| 2022 | $832.2 | $50.9 | $7.6 | -$37.8 | $20.6 | 2.5% |
| 2023 | $881.7 | $58.0 | $8.1 | -$39.4 | $26.7 | 3.0% |
| 2024 | $934.0 | $66.2 | $8.7 | -$40.8 | $34.0 | 3.6% |
| 2025 | $989.5 | $74.5 | $9.2 | -$42.5 | $41.1 | 4.2% |
| 2026 | $1,048.3 | $83.9 | $9.6 | -$44.1 | $49.4 | 4.7% |
| 2027 | $1,110.6 | $94.6 | $9.9 | -$45.7 | $58.8 | 5.3% |
| 2028 | $1,176.5 | $106.8 | $9.9 | -$47.2 | $69.5 | 5.9% |
| 2029 | $1,246.4 | $120.8 | $9.5 | -$48.6 | $81.6 | 6.5% |
| 2010-2019 | $5,514.4 | $187.9 | $16.7 | -$224.6 | -$19.9 | -0.4% |
| 2020-2029 | $9,746.4 | $740.0 | $86.0 | -$417.2 | $408.7 | 4.2% |
| 2010-2029 | $15,260.8 | $927.8 | $102.7 | -$641.8 | $388.8 | 2.5% |

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

We estimate that employer costs would increase by about $187.9 billion as the cost of the various excise taxes is passed on to payers over the 2020 through 2019 period. Cost-shifting would add another $16.7 billion to employer costs over this period. Employers would save $224.6 billion due to other program effects over this period, primarily due to reductions in the number of employers offering coverage.

Private employer health spending would increase by about $408.7 billion over the 2020 through 2029 period. These increases in spending are driven by the increasing amount of the excise tax on high-cost plans and growing cost-shifting from increasing reductions in payments for services under the Medicare and Medicaid programs. Over the following decade, employers would pay an additional $740 billion in excise taxes and would see cost-shifting of $86.0 billion (*Figure 12*).

### 3. *Impact on Employer Costs by Industry and Firm Size*

*Figure 15* presents our estimates of the average change in employer health spending per worker for private employers by firm size, industry and current insuring status, assuming the program is fully implemented in 2011. Firms that now offer insurance to at least some of their workers would see a net reduction in health spending averaging $268 per employee. This reflects primarily the reductions in employer coverage under the Act.

By comparison, firms that do not now offer insurance would see an increase in health spending per worker of about $301 per year. This includes the cost of benefits for employers who decide to offer insurance and penalty payments for employers who continue not to offer coverage. The average change in employer spending across all employers (currently insuring and non-insuring) would be reduction of $118 per worker. Small firms currently offering insurance would see savings averaging $950 per worker, reflecting the new employer tax credit and the advantage of purchasing coverage through the exchanges under the Act.

### Figure 15
### Change in Employer Health Spending per Worker under the America's Healthy Future Act Assuming it is Fully Implemented in 2011[/a]

| | Currently Insuring Firms | Currently Non-insuring Firms | All Firms |
|---|---|---|---|
| **Firm Size (number of workers)** | | | |
| Fewer than 10 | -$950 | $410 | -$216 |
| 10-24 | -$776 | $275 | -$301 |
| 25-99 | -$464 | $204 | -$275 |
| 100-499 | -$151 | $231 | -$83 |
| 500-999 | -$26 | $184 | $7 |
| 1,000-4,999 | -$105 | $261 | $0 |
| 5,000 or more | $42 | $0 | $42 |
| **Industry** | | | |
| Construction | -$299 | $2 | $2 |
| Manufacturing | -$324 | -$230 | -$230 |
| Transportation | -$136 | -$14 | -$14 |
| Wholesale Trade | -$137 | -$63 | -$63 |
| Retail Trade | -$312 | -$171 | -$171 |
| Services | -$222 | -$78 | -$78 |
| Finance | -$356 | -$234 | -$234 |
| Other | -$396 | -$133 | -$133 |
| **All Private Employers** | | | |
| Total Private | -$268 | $301 | -$118 |

a/ For illustrative purposes, this scenario assumes that the Act is fully implemented and enrollment is fully matured in 2011.
Source: Lewin Group Estimates Using the Health benefits Simulation Model (HBSM).

## E. Impact on Consumers

Under current law, families will spend an average of about $4,193 per family for health care in 2011 (*Figure 16*). This includes average premium payments of $2,648 and average out-of-pocket expenses for health services of $1,545. Premiums include the amounts paid for individual non-group coverage and employee contributions for ESI. Out-of-pocket expenses include deductibles and co-payments for covered services as well as family spending for services not covered by insurance. These include amounts spent by families out-of-pocket for services by the uninsured.

### Figure 16
### Average Family Health Spending by Family Income under Current Law in 2011

| | Number of Families (thousands) | Spending under Current Law | | |
|---|---|---|---|---|
| | | Average Premium | Average Out-of-Pocket | Average Total Spending |
| **Families by Annual Family Income** | | | | |
| Under $10,000 | 13,257 | $479 | $717 | $1,196 |
| $10,000-$19,999 | 15,579 | $1,124 | $831 | $1,955 |
| $20,000-$29,999 | 14,716 | $1,828 | $1,143 | $2,971 |
| $30,000-$39,999 | 14,434 | $2,200 | $1,285 | $3,485 |
| $40,000-$49,999 | 11,759 | $2,684 | $1,576 | $4,260 |
| $50,000-$74,999 | 21,278 | $3,055 | $1,671 | $4,726 |
| $75,000-$99,999 | 15,403 | $3,721 | $1,978 | $5,699 |
| $100,000-$149,999 | 16,203 | $3,988 | $2,103 | $6,091 |
| $150,000 or More | 13,135 | $4,449 | $2,540 | $6,989 |
| **All Families** | | | | |
| All Families | 135,765 | $2,648 | $1,545 | $4,193 |

Source: Lewin Group Estimates Using the Health Benefits Simulation Model (HBSM).

Average annual health spending would increase by $218 per family under the Act (*Figure 17*). Premium expenses would increase by about $3 per family. However, with incomes below $50,000 would generally pay less for premiums due to the Medicaid expansion and the premium tax credit under the Act.

Out-of-pocket spending would increase by an average of $130 per family, partly due to increased utilization of health services for newly insured individuals. It also reflects that the "Bronze" health plan under the Act would have relatively higher cost-sharing than typical employer coverage.

## Figure 17
## Changes in Family Health Spending under the America's Healthy Future Act by Family Income in 2011 [a/]

| | Change in Premiums | Change in Out-of Pocket | Penalty Payments | After tax Wage Effects [b/] | Net Change in Spending |
|---|---|---|---|---|---|
| Under $10,000 | -$218 | -$179 | $8 | $56 | -$445 |
| $10,000-$19,999 | -$102 | -$124 | $17 | $62 | -$271 |
| $20,000-$29,999 | -$150 | $19 | $67 | $140 | -$204 |
| $30,000-$39,999 | -$102 | $98 | $70 | $103 | -$37 |
| $40,000-$49,999 | -$15 | $118 | $95 | -$16 | $214 |
| $50,000-$74,999 | $145 | $294 | $133 | $40 | $532 |
| $75,000-$99,999 | $143 | $295 | $195 | $47 | $586 |
| $100,000-$149,999 | $138 | $257 | $243 | $0 | $638 |
| $150,000 or More | $96 | $304 | $316 | -$60 | $776 |
| **All Families** | **$3** | **$130** | **$128** | **$43** | **$218** |

a/ For illustrative purposes, this scenario Assumes that the Act is fully implemented and enrollment is fully matured in 2011.
b/ Increases to wages are counted as a reduction in family health care costs.
Source: Lewin Group Estimates Using the Health Benefits Simulation Model (HBSM).

We also estimate that average annual after-tax wages would decline by about $43 per family due to increased spending for health by employers. In this analysis, we assume that changes in employer health benefits costs – whether they are increases or decreases - are passed back to workers in the form of wage adjustments. This is based upon research on changes in wages associated with increased spending for employee health benefits.[5] Thus, an increase in employer costs is passed back to workers as reduced wage growth over time, while reductions in employer costs are passed on as increased wage growth.[6] In this analysis, we treat the reduction in wages due to increases in employer costs as an increase in family health care spending.

While families overall would see an increase in health care spending (i.e., $218 per family), the change in spending would vary widely with the age of the family head (*Figure 18*). Health spending would increase by $388 per family headed by someone age 25 to 34. The increase in spending declines as age increases. Family spending would increase by about $180 per family for families headed by someone age 55 to 64, reflects limitations on premium variation by age under the insurance reform provisions of the Act (i.e., the Act limits premium variation with age to 4:1).

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5    See, for example, James Heckman, "What Has Been Learned About Labor Supply in the Past Twenty years?" American Economic Review, (May 1993).
6    See, for example, Jonathan Gruber and Alan B. Kreuger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers Compensation Insurance," in Tax Policy and the Economy (1991); Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," American Economic Review, (forthcoming); and Lawrence H. Summers, "Some Simple Economics of Mandated Benefits," American Economic Review (May 1989).

Figure 18
**Changes in Average Family Health Spending under the America's Healthy Future Act by Age of Family Head: 2011** [a/,b/]
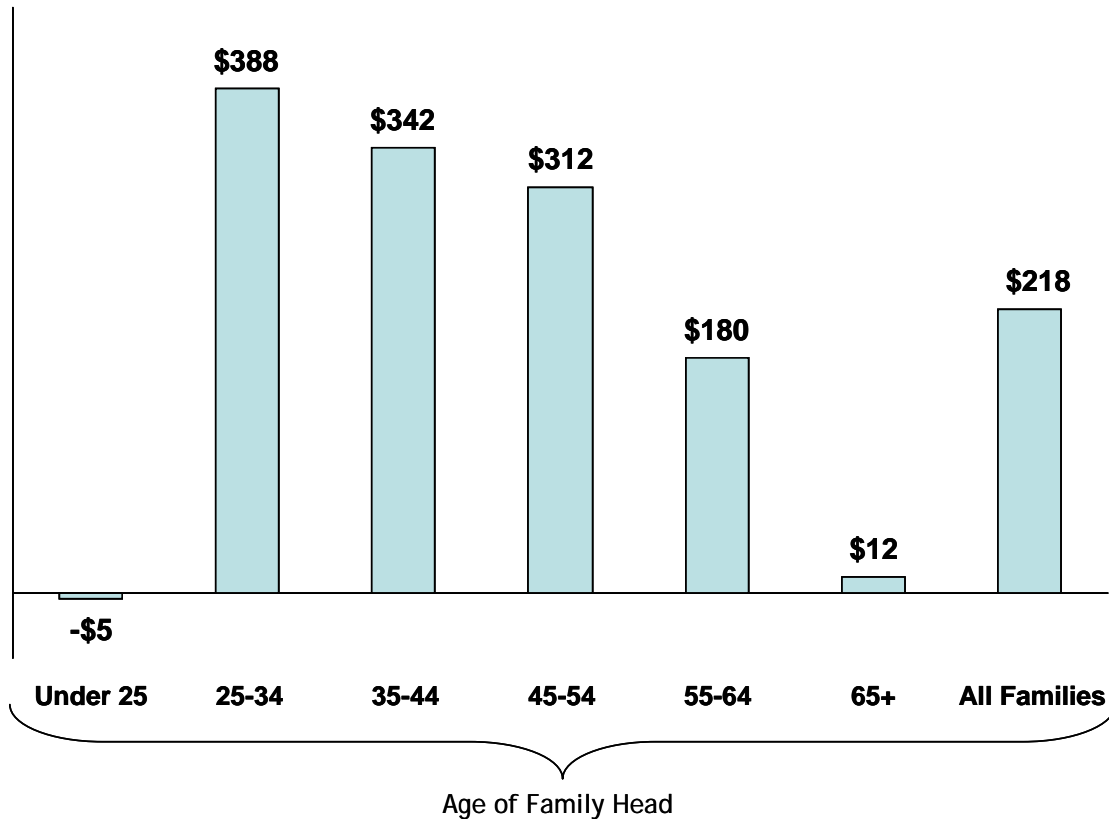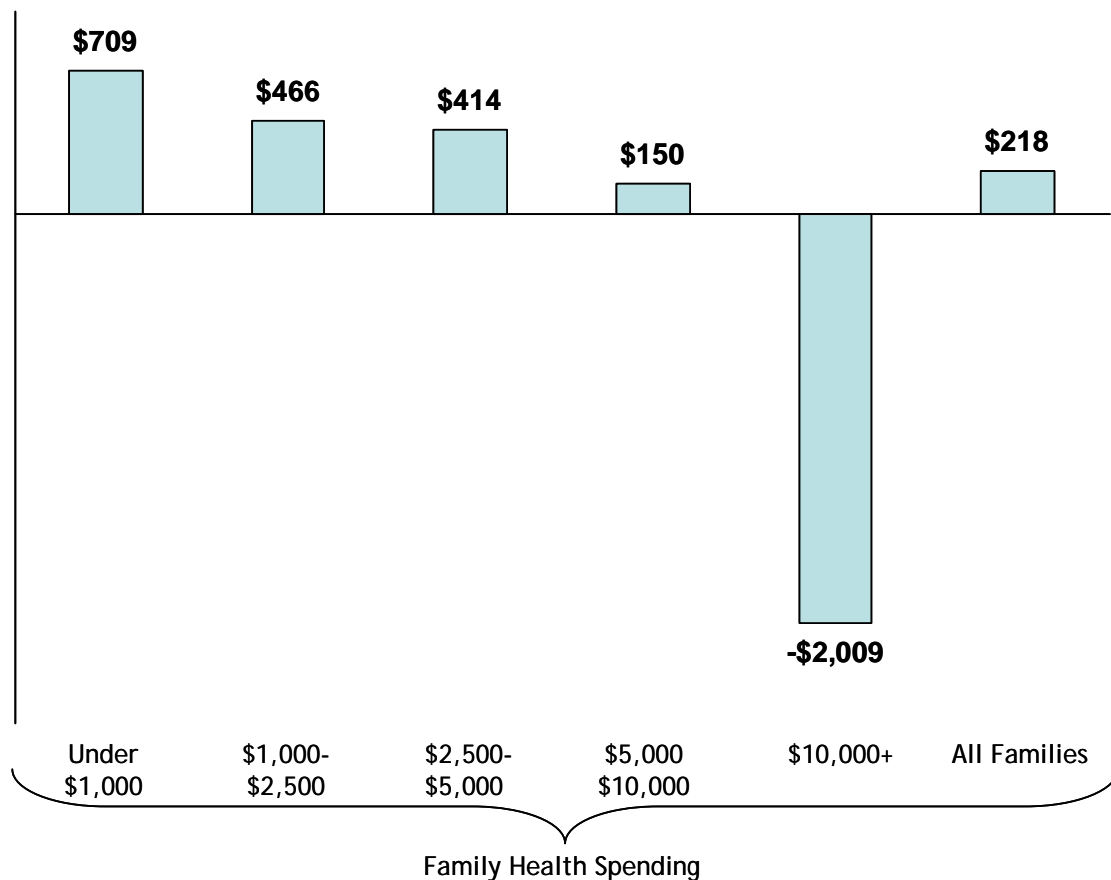


a/ For illustrative purposes, this scenario Assumes that the Act is fully implemented and enrollment is fully matured in 2011.
b/ Does not reflect changes in Medicare premiums and reductions in benefits due to changes in the MA program.
Source:  The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The Act would provide the greatest savings to those who have high health care expenses under current law. Savings would average about $2,000 for families that would experience total family health spending of $10,000 or more under current law (*Figure 19*). By contrast, families that would have had health expenses of less than $1,000 under current law would spend an average of $708 more per family under the Act.

Figure 19

**Changes in Average Family Health Spending by Current Insured Status and Current Family Spending
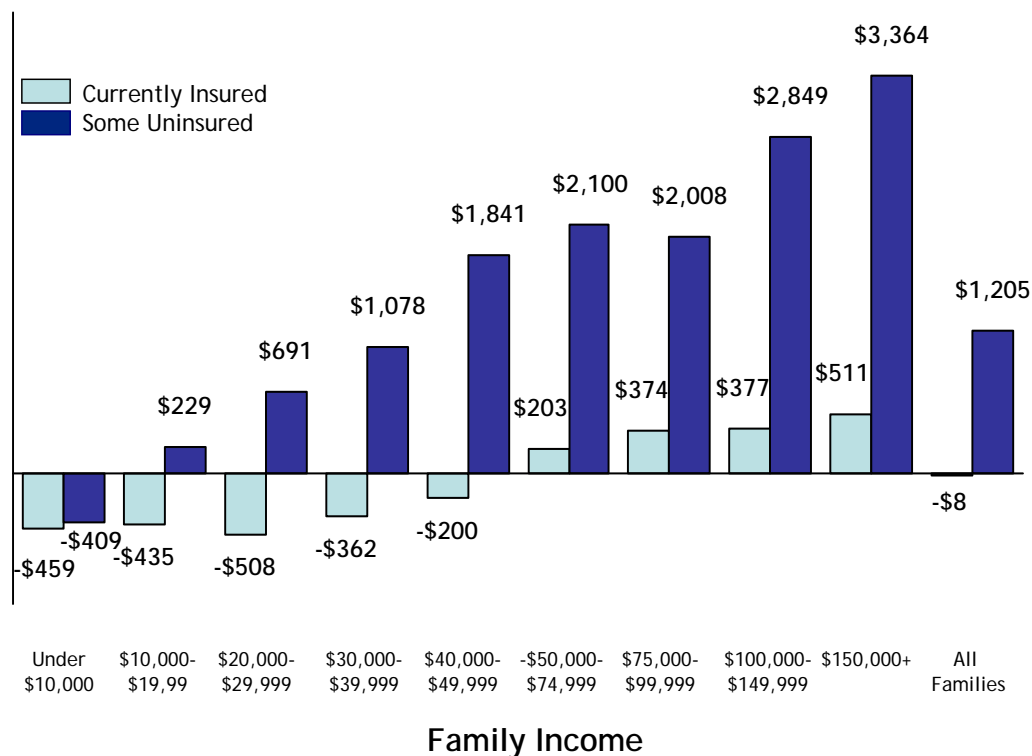Level under the America's Healthy Future Act: 2011** [a]



a/ For illustrative purposes, this scenario Assumes that the Act is fully implemented and enrollment is
fully matured in 2011.
Source:  The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The impact of the Act on families would vary with the current insured status of family
members. Families where all members would have been insured under current law would save
an average of $8 per family per year (*Figure 20*). Insured families with annual incomes of less
than $50,000 per year would on average see savings. For example, savings would average about
$500 per insured family for those with annual incomes between $20,000 and $30,000.

Figure 20

**Changes in Average Annual Family Health Spending by Family Income and Current Insured Status under the America's Healthy Future Act, Assuming full Implementation in 2011[a]**



**Family Income**

a/ For illustrative purposes, this scenario Assumes that the Act is fully implemented and enrollment is fully matured in 2011.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

However, spending for families who currently have one or more uninsured members would pay about $1,205 per family more for health than they would under current law. This reflects the cost of coverage and/or penalties for failing to have insurance. Because the uninsured tend to be younger and relatively low users of health services, the cost of insurance for this group generally would be greater than what they save in out-of-pocket health care costs by having coverage.

In *Figure 21* we present estimates of the change in total health expenditures for all families under the Act.

Figure 21
Changes in Health Spending for Families under the America's Healthy Future Act of 2009 (billions)

| | Total Household Health Spending | Change in Health Spending | Percent Change |
|---|---|---|---|
| 2010 | $722.3 | $4.3 | 0.6% |
| 2011 | $755.8 | $10.1 | 1.4% |
| 2012 | $788.6 | $11.9 | 1.6% |
| 2013 | $831.3 | -$3.6 | -0.3% |
| 2014 | $875.6 | $14.1 | 1.8% |
| 2015 | $926.7 | $31.0 | 3.5% |
| 2016 | $983.5 | $36.3 | 3.9% |
| 2017 | $1,044.0 | $43.2 | 4.4% |
| 2018 | $1,109.4 | $49.3 | 4.7% |
| 2019 | $1,175.3 | $57.0 | 5.2% |
| 2020 | $1,249.2 | $62.0 | 5.3% |
| 2021 | $1,327.8 | $68.1 | 5.5% |
| 2022 | $1,411.8 | $75.0 | 5.6% |
| 2023 | $1,501.1 | $83.3 | 5.9% |
| 2024 | $1,596.0 | $92.6 | 6.1% |
| 2025 | $1,696.9 | $101.8 | 6.3% |
| 2026 | $1,804.3 | $112.0 | 6.6% |
| 2027 | $1,918.5 | $123.7 | 6.8% |
| 2028 | $2,039.7 | $136.5 | 7.0% |
| 2029 | $2,168.5 | $150.6 | 7.3% |
| **2010-2019** | $9,212.5 | $253.6 | 2.9% |
| **2020-2029** | $16,713.7 | $1,005.4 | 6.4% |
| **2010-2029** | $25,926.3 | $1,259.0 | 5.1% |

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

## F.  Impact on National Health Spending

The actuaries of the CMS estimate that national health spending will reach $2.77 trillion in 2011. This includes expenditures for health services, prescription drugs, medical equipment, public health, research and construction. It includes the amounts spent by all payer groups including the federal government, state and local governments, employers and families.

In this analysis, we estimated the change in total health spending in the U.S., regardless of payer source for 2010 through 2029. Also, to illustrate the impact of the Act on national health spending, we estimated its effect on health expenditures assuming that the program is fully implemented and enrollment is fully mature in 2011.

### 1. Changes in National Health Spending

We estimate that national health spending would increase by about $36.3 billion if the Act were fully implemented in 2011 (*Figure 22*).  We estimate an overall increase in utilization of health services of roughly $34.6 billion for the newly insured and those obtaining improved coverage.

In addition, utilization of health services would increase by another $2.7 billion for people who now have improved coverage due to the Act.

Figure 22
Change in National Health Spending Under the America's Healthy Future Act Assuming Full Implementation in 2011 (billions) [a]

| | | Changes in National Health Spending |
|---|---|---|
| National Health Spending in 2011 | | $2,770.3 |
| Changes in Health Spending under the Act | | |
| Net Change in Spending for Health Services | | $31.2 |
| Change in Utilization for Newly Insured | $34.6 | |
| Change in Utilization due to Improved Coverage | $2.7 | |
| Change in Utilization due to Excise Taxes | -$4.9 | |
| Connector Competition Effect | -$1.2 | |
| Change in Provider Income | | -$1.3 |
| Payments for Formerly Uncompensated Care | $16.5 | |
| Change in Provider Payment Rates | | |
| Enrollees Moving from Private Coverage to Medicaid | -$3.7 | |
| Enrollees Moving from Medicaid to Private Coverage | $3.7 | |
| Medicare and Medicaid payment reductions [b] | -$18.7 | |
| Increased Cost Shifting (Assumes 40 percent passed to Payers) | $0.9 | |
| Other Medicare and Medicaid | | -0.7 |
| Change in Insurer Administrative Costs | | $7.1 |
| Change in Insurer Administration (including Medicaid) | $4.6 | |
| Administration of Subsidies | $2.5 | |
| Net Change in National Health Spending | | $36.3 |

a/ For illustrative purposes, this figure shows the impact of the Act assuming the program is fully implemented and enrollment is fully matured in 2011.
b/ This is the reduction in federal spending for provider payments under Medicare and Medicaid estimated by the CBO for 2014 (adjusted to 2011 levels), which is the first year of the coverage expansion provisions of the Act.
Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM).

We estimate savings of about $1.2 billion due to increased competition through the exchange. In addition, we estimate a spending reduction of $4.9 billion due to the excise tax. This reflects our assumption (discussed above) that the excise taxes will be passed on to consumers as higher premiums, which would be associated with a small reduction in health service utilization (i.e., price effect).

We estimate an overall increase in insurer administrative costs for private insurance and public programs of $7.1 billion under the Act. This includes the cost of administering coverage for the newly insured and the cost of processing incomes to determine eligibility for Medicaid and the premium tax credit.

There are several features of the proposal that would affect provider payments for services, which would have an impact on provider cost shifting. Providers now would be paid for services that under current law would have been provided free as uncompensated care, adding $16.5 billion to provider incomes. Provider reimbursement would increase by about $3.7 billion for those now covered under Medicaid who would become covered by employers who decide to offer coverage to avoid the employer penalty. Similarly, there would be a reduction in reimbursement of $3.7 billion for people who shift to Medicaid from employer coverage in cases where an employer has decided to discontinue coverage under the Act.

However, proposed reductions in provider payments under Medicare and Medicaid would reduce provider revenues for the services they provide by $18.7 billion if fully implemented in 2011 (based upon CBO estimated savings for 2013, adjusted to 2011 spending levels). The combined impact of these changes would be a net reduction in provider reimbursement of $2.2 billion. This includes the reductions in reimbursement under Medicare less the increase in revenues from reduced uncompensated care.

Based upon the available research, we assume that 40 percent of any net change in provider reimbursement levels under public programs and/or reduction in uncompensated care would be passed back to the consumers in the form of a change in for private insurers. This results in a net increase in the cost-shift of $900 million.

### 2. Long-term Impacts on Cost-shifting

The theory of cost shifting is that health care providers will pass-on at least some portion of the cost of uncompensated care and shortfalls in provider reimbursement to privately insured people in the form of increased charges for services. Thus, reductions in provider reimbursement under public programs are likely to result in increased costs for privately insured people.

In evaluating the impact of reform on the cost shift, it is important to distinguish provider payment reductions from reductions in beneficiary services. For example, of the $404.2 billion in Medicare and Medicaid reductions in the Act, only about $241.9 billion would be in the form of payment reductions. The reductions in payments to Medicare Advantage (MA) plans would cause plans to reduce the additional benefits provided to beneficiaries under the program, but are unlikely to affect provider payments. The Act also includes a temporary increases in Part B premiums for higher income beneficiaries of about $22.2 billion, which would increase costs to beneficiaries, but would not directly affect provider payments.

As discussed above, it is important to offset these reductions in reimbursement with increases in reimbursement due to reduced uncompensated care and any change in enrollment under Medicaid, which pay providers substantially less than both Medicare and private insurers. We then assume that the cost-shift will be equal to 40 percent of the net change in reimbursement. Using these assumptions, we estimate a net increase in the cost-shift of about $34.4 billion over the 2010 through 2019 period, and $190.9 billion over the following decade *Figure 23.*

Our assumption that 40 percent of these changes in reimbursement are passed back to private payers is based upon studies of the effect of reductions in provider reimbursement. There are two separate studies indicating that about one-half of hospital payment shortfalls are passed-on

to private payers in the form of higher charges.[7] However, two other studies showed considerably less evidence of hospital cost-shifting, although they did not rule out a partial cost-shift.[8]

## Figure 23
## Estimated Cost Shift Resulting from the America's Healthy Future Act of 2009

| | Reductions in Uncompensated Care | People Moving from Private to Medicaid | People Moving from Medicaid to Private | Changes in Medicare and Medicaid Provider Payments | Total Net Change In Provider Reimbursement | Amount of Cost Shift [a/] |
|---|---|---|---|---|---|---|
| 2010 | $0.0 | $0.0 | $0.0 | $9.0 | $9.0 | -$3.6 |
| 2011 | $0.0 | $0.0 | $0.0 | $6.3 | $6.3 | -$2.5 |
| 2012 | $0.0 | $0.0 | $0.0 | -$3.1 | -$3.1 | $1.2 |
| 2013 | $7.5 | $0.0 | $1.7 | -$9.2 | $0.0 | $0.0 |
| 2014 | $18.1 | -$1.8 | $4.0 | -$28.7 | -$8.4 | $3.4 |
| 2015 | $21.6 | -$4.4 | $4.8 | -$30.6 | -$8.5 | $3.4 |
| 2016 | $23.2 | -$5.2 | $5.2 | -$34.9 | -$11.7 | $4.7 |
| 2017 | $25.1 | -$5.6 | $5.6 | -$41.7 | -$16.6 | $6.7 |
| 2018 | $27.0 | -$6.0 | $6.0 | -$49.0 | -$22.0 | $8.8 |
| 2019 | $29.0 | -$6.5 | $6.5 | -$60.0 | -$31.0 | $12.4 |
| 2020 | $31.3 | -$7.0 | $7.0 | -$64.5 | -$33.3 | $13.3 |
| 2021 | $33.7 | -$7.6 | $7.6 | -$69.7 | -$36.0 | $14.4 |
| 2022 | $36.3 | -$8.1 | $8.1 | -$75.1 | -$38.9 | $15.5 |
| 2023 | $39.1 | -$8.8 | $8.8 | -$80.9 | -$41.8 | $16.7 |
| 2024 | $42.1 | -$9.4 | $9.4 | -$86.7 | -$44.6 | $17.8 |
| 2025 | $45.3 | -$10.2 | $10.2 | -$92.6 | -$47.3 | $18.9 |
| 2026 | $48.8 | -$10.9 | $10.9 | -$98.3 | -$49.5 | $19.8 |
| 2027 | $52.5 | -$11.8 | $11.8 | -$103.5 | -$51.0 | $20.4 |
| 2028 | $56.6 | -$12.7 | $12.7 | -$107.7 | -$51.1 | $19.6 |
| 2029 | $60.9 | -$13.7 | $13.7 | -$109.8 | -$48.9 | $34.4 |
| 2010-2019 | $151.4 | -$29.5 | $34.0 | -$241.9 | -$86.0 | $34.4 |
| 2020-2029 | $446.4 | -$100.1 | $100.1 | -$888.8 | -$442.4 | $190.9 |
| 2010-2029 | $597.9 | -$129.7 | $134.1 | -$1,130.7 | -$528.5 | $225.4 |

a/ Assumed that 40 percent of the net change in provider reimbursement and uncompensated care is passed back to the privately insured as increased charges.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

One study of physician pricing by Thomas Rice et al., showed that for each one percent reduction in physician payments under public programs, private sector prices increased by 0.2

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[7] Dranove, David, "Pricing by Non-Profit Institutions: The Case of Hospital Cost Shifting," *Journal of Health Economics*, Vol. 7, No. 1 (March 1998); and Sloan, Frank and Becker, Edward, "Cross-Subsidies and Payment for Hospital Care," *Journal of Health Politics, Policy and Law*, vol. 8., No. 4 (Winter 1984)

[8] Zuckerman, Stephen, "Commercial Insurers and All-Payer Regulation," *Journal of Health Economics*, Vol. 6. No. 2 (September 1987); and Hadley, Jack and Feder, Judy, "Hospital Cost Shifting and Care for the Uninsured," *Health Affairs*, Vol. 4 No. 3 (Fall 1985)

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percent.[9] Our own analysis of hospital data indicates that about 40 percent of the increase in hospital payment shortfalls (i.e., revenues minus costs) in public programs were passed-on to private-payers in the form of the cost shift during the years studied.[10]

### 3. Spending by Payer Group

*Figure* 24 presents our estimates of the changes in health spending for four major payer groups: the federal government, state and local governments, private employers and families. We present these estimates with and without expected wage effects. As discussed above, we assume that increases in employer health spending under the mandate would be passed back to workers in the form of reduced wage growth, which has implications for federal and state income and payroll tax revenues.

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[9]  Rice, Thomas, et al., "Physician Response to Medicare Payment Reductions: Impacts on public and Private Sectors," Robert Wood Johnson Grant No. 20038, September 1994.

[10]  Sheils, J., Claxton, G., "Potential Cost Shifting Under Proposed Funding Reductions for Medicare and Medicaid: The Budget Reconciliation Act of 1995," (Report to the National Coalition on Health Care), The Lewin Group, December 6, 1995

**Figure 24**
**Changes in Health Spending By Payer Group under the America's Healthy Future Act of 2009: 2010-2029 (billions)**

| | Before Accounting for Wage and Tax Effects | | | | | After Accounting for Wage and Tax Effects | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Change in Net Federal Spending | State & Local Government Spending | Private Employer Spending | Family Health Spending | Total Health Spending | Change in Net Federal Spending | State & Local Government Spending | Private Employer Spending | Family Health Spending | Total Health Spending |
| 2010 | $0.5 | $0.8 | $4.4 | $0.7 | $6.4 | -$0.4 | $0.7 | $1.8 | $4.3 | $6.4 |
| 2011 | -$8.3 | $1.6 | $2.2 | $8.3 | $3.8 | -$9.0 | $1.5 | $1.2 | $10.1 | $3.8 |
| 2012 | -$18.9 | $2.2 | $1.5 | $10.7 | -$4.5 | -$19.6 | $2.1 | $1.1 | $11.9 | -$4.5 |
| 2013 | -$29.2 | -$8.9 | -$13.6 | $8.0 | -$43.7 | -$27.8 | -$8.8 | -$3.5 | -$3.6 | -$43.7 |
| 2014 | -$10.5 | -$4.6 | -$17.1 | $29.0 | -$3.2 | -$8.8 | -$4.4 | -$4.1 | $14.1 | -$3.2 |
| 2015 | $22.1 | -$10.5 | -$5.7 | $36.0 | $41.9 | $21.4 | -$10.6 | $0.1 | $31.0 | $41.9 |
| 2016 | $22.7 | -$11.1 | -$2.8 | $38.6 | $47.4 | $21.0 | -$11.3 | $1.4 | $36.3 | $47.4 |
| 2017 | $14.9 | -$11.0 | -$0.1 | $42.9 | $46.8 | $12.3 | -$11.3 | $2.6 | $43.2 | $46.8 |
| 2018 | $7.2 | -$10.8 | $3.3 | $45.9 | $45.5 | $3.5 | -$11.2 | $3.9 | $49.3 | $45.5 |
| 2019 | -$3.4 | -$10.0 | $7.9 | $49.4 | $43.9 | -$8.4 | -$10.5 | $5.8 | $57.0 | $43.9 |
| 2020 | -$4.9 | -$10.3 | $11.3 | $51.2 | $47.3 | -$10.9 | -$10.9 | $7.1 | $62.0 | $47.3 |
| 2021 | -$7.5 | -$10.6 | $15.5 | $53.5 | $50.9 | -$14.6 | -$11.3 | $8.7 | $68.1 | $50.9 |
| 2022 | -$10.6 | -$10.8 | $20.6 | $55.7 | $54.9 | -$19.1 | -$11.6 | $10.6 | $75.0 | $54.9 |
| 2023 | -$14.8 | -$10.9 | $26.7 | $58.3 | $59.4 | -$24.8 | -$11.9 | $12.8 | $83.3 | $59.4 |
| 2024 | -$19.6 | -$10.8 | $34.0 | $60.8 | $64.5 | -$31.5 | -$12.0 | $15.4 | $92.6 | $64.5 |
| 2025 | -$23.6 | -$11.1 | $41.1 | $63.5 | $70.0 | -$37.3 | -$12.4 | $17.9 | $101.8 | $70.0 |
| 2026 | -$27.9 | -$11.1 | $49.4 | $66.0 | $76.3 | -$43.7 | -$12.6 | $20.7 | $112.0 | $76.3 |
| 2027 | -$32.6 | -$11.1 | $58.8 | $68.7 | $83.8 | -$50.8 | -$12.9 | $23.8 | $123.7 | $83.8 |
| 2028 | -$37.1 | -$11.1 | $69.5 | $71.4 | $92.7 | -$58.0 | -$13.1 | $27.4 | $136.5 | $92.7 |
| 2029 | -$41.0 | -$10.9 | $81.6 | $74.1 | $103.8 | -$64.8 | -$13.2 | $31.3 | $150.6 | $103.8 |
| 2010-2019 | -$3.0 | -$62.4 | -$19.9 | $269.6 | $184.2 | -$15.9 | -$63.7 | $10.2 | $253.6 | $184.2 |
| 2020-2029 | -$219.5 | -$108.7 | $408.7 | $623.2 | $703.7 | -$355.4 | -$121.9 | $175.6 | $1,005.4 | $703.7 |
| 2010-2029 | -$222.4 | -$171.2 | $388.8 | $892.7 | $887.9 | -$371.3 | -$185.6 | $185.8 | $1,259.0 | $887.9 |

a/ Reflects changes in wages for employer health spending among non-government employers only.
b/ Changes in employer costs attributed to retirees are retained as costs to the employer because retiree costs have no impact on labor markets for workers.
Source: Lewin Group Estimates Using the Health Benefits Simulation Model (HBSM).

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495261

## Simulation of the America's Healthy Future Act of 2009

We estimated the cost and coverage impacts of The America's Healthy Future Act of 2009 using The Lewin Group Health Benefits Simulation Model (HBSM). To facilitate comparison of these proposals, we adopted a standard set of data and assumptions that were applied uniformly across all of our similar studies. While it is difficult to predict the precise impact of these proposals, the use of a standard methodology assures that comparisons of results across plans reflect differences in program design rather than mere inconsistencies in assumptions.

The HBSM is a micro-simulation model of the US health care system. Central to its design is a "base case" scenario depicting the distribution of health insurance coverage, as well as expenditures across a representative sample of households in the US under current policy for a base year. We assumed the base year to be 2010. The resulting database provides a detailed accounting of coverage and spending in the US health care system for consumers, employers, state and local governments and the federal government.

We used the model to simulate the effect of the Bill on the number of people with health insurance from public and private sources. We estimated changes in health care costs for major payers for health services including households, employers and governments. The impact of each proposal is determined by calculating the difference between coverage and health spending levels under each proposal and coverage and spending levels under current law (i.e., our baseline simulation). Estimates of employer effects are provided by firm size, industry, earnings levels and current insuring status. Changes in consumer spending are provided by income, age, current insured status and various demographic characteristics.

In this analysis, we projected the impact of each health reform proposal on health spending and the federal budget for the 2010 through 2019 period. In developing these projections, we used assumptions developed by the Office of the Actuary of CMS on the growth in Gross Domestic Product (GDP), population growth and the growth, in health spending by type of service and source of payment. A full documentation of HBSM and the data used is available upon request.

## A. Population Data

Our baseline household data is based upon the Medical Expenditures Panel Survey (MEPS) data for 2002 through 2005, which are the most recent complete MEPS data now available. These data provide detailed information on health insurance coverage, health spending by type of service and source of payment, income and employment status and the demographic composition of the population. These data were adjusted to reflect more recent information on the distribution of the population by source of coverage, income, employment status and other socio-demographic characteristics provided in the Current Population Survey (CPS) for 2007.[11]

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[11] Both the MEPS and the CPS data are corrected for under-reporting of Medicaid coverage, which is quite severe in the CPS. These databases provide comparable variable definitions that permit us to perform these necessary adjustments.

495261

These data were then "aged" to be representative of the US population in 2006, which is the base year of the analysis. We used population growth projections from the Bureau of the Census and income growth assumptions consistent with those used by the Office of the Actuary of the Center for Medicare & Medicaid Services (CMS) in developing their health spending projections. We then adjusted the health spending data reported by households in the MEPS to replicate the distribution of total personal health expenditures by type of service and source of payment.

## B.  Simulation of Medicaid Eligibility and Enrollment

The Bill includes an expansion in eligibility for the Medicaid and SCHIP programs. We simulated this using the CPS data for 2007. We used these data to identify people eligible for these programs under current law using the actual income eligibility levels used in each state under current law by class of eligibility (i.e., children, parents and childless adults). We then used the model to identify the number of people who would be eligible for coverage under the plan including parents and non-custodial adults living below 150 percent of the FPL.

The impact of these expansions will vary across states, due to the wide variation in income eligibility levels under the current Medicaid program. Although eligibility levels vary considerably across states, children are usually covered up to 200 percent of the FPL. Parents are eligible if their income is below levels averaging about 50 percent of the FPL. Noncustodial, nondisabled adults generally are not eligible at any income level, except in about 6 states that have been granted waivers to cover this population.

Once we identified the newly eligible population, we estimated the number of people who would enroll using multivariate analyses of historical enrollment levels under the existing program. These analyses show how enrollment varies with age, income, eligibility group and whether they have access to employer-sponsored insurance (ESI). The model also shows how enrollment levels are affected when participants are required to pay a premium, as is done in some states for people at the higher end of the eligibility scale.

Our program cost estimates were estimated using the health spending data in HBSM for those who are simulated to become covered under the expansion. For newly insured people, we assumed that their utilization of health services would increase to the levels reported by insured people with similar age, gender, income and health status characteristics.

## C.  Premium Subsidies

The Bill would provide subsidies to assist people in purchasing private insurance coverage. In our analysis, we assume that people treat these subsidies as a reduction in their cost of health insurance. We assume that these subsidies induce some of the uninsured to choose to purchase non-group coverage. We estimate the number of people who obtain insurance, based upon a multivariate analysis of how the likelihood of purchasing coverage increases as the cost of insurance, is reduced.

These data show that, on average, each 1 percent reduction in the price of insurance is associated with a 0.34 percent increase in the percentage of people purchasing coverage.[12] However, as shown in *Figures A-1* and *A-2,* these data indicate that the magnitude of the price response tends to decline at higher income and age levels. These price response factors are used as probabilities to select eligible people in the model to take coverage in response to the subsidies.
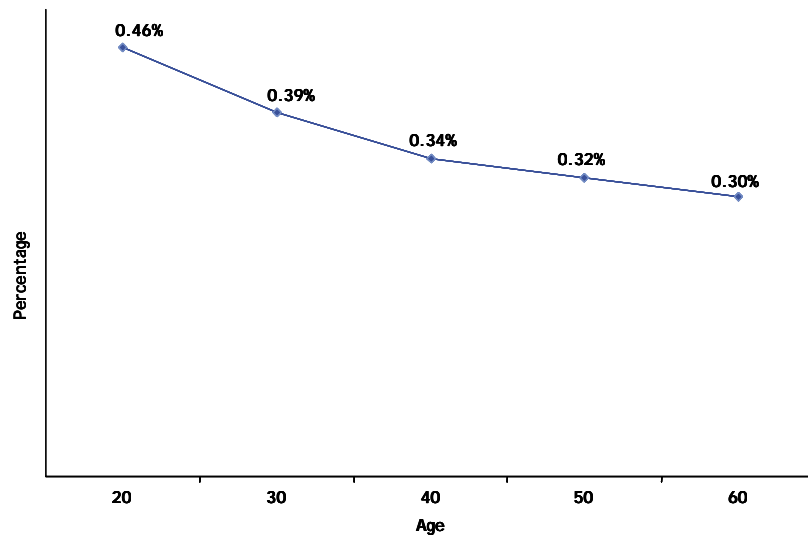
Figure A-1:
Percentage Increase in Coverage Resulting from a One Percent Reduction
in Premiums by Income Level[a/]
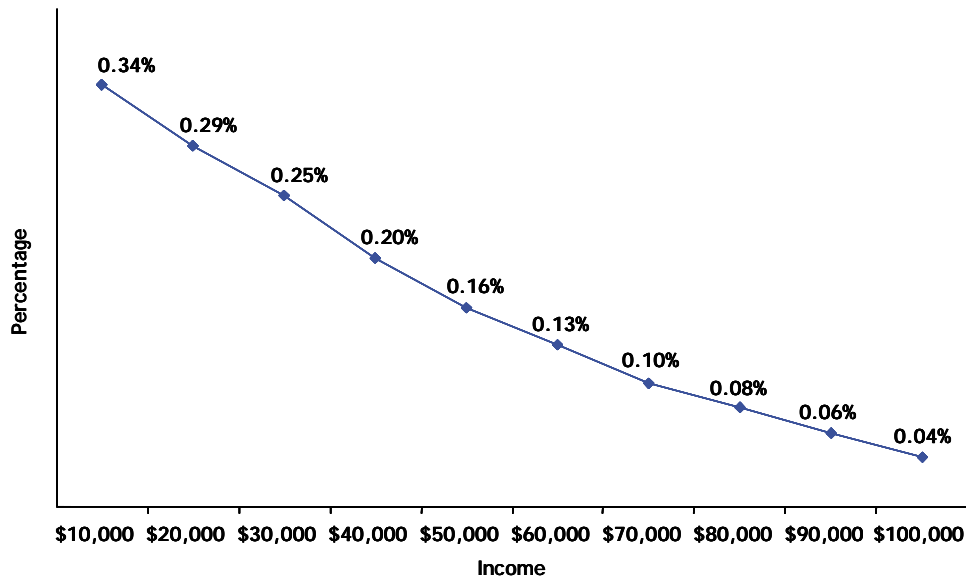


a/ Indicates a price elasticity ranging between -0.55 to -0.09 by income.
Source:   The Lewin Group estimates.

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[12]    Students of economics will recognize this as a price "elasticity."

495261

a/ Indicates a price elasticity ranging between –0.46 and –0.30 by age.
Source:  The Lewin Group estimates.

Once changes in sources of coverage are modeled, HBSM simulates the amount of covered health spending for each affected individual based upon the health utilization and spending data reported for each individual selected to become covered. This includes simulating the increase in utilization among newly insured people. In general, we assume that utilization among newly insured people will increase to the level reported by insured people with similar characteristics. The benefit costs are estimated from these spending data based upon the covered services and cost-sharing provisions of a typical health plan, or the minimum benefits package that is specified under the legislation.[13]

## D.  Employer Impacts

The Bill provides a tax credit to small employers for up to half of premium contributions and establishes a governmental reinsurance program that reduces the cost of employer health insurance. Both plans also include provisions designed to reduce health care costs (e.g., malpractice reforms, etc.) that would influence employers, decisions about offering coverage.

Modeling these effects requires a representative sample of employers with detailed information on the characteristics of each employer, together with information on the characteristics of each worker and dependent in the firm, including health spending information. Because no one database provides this combination of employer and employee data, we developed "synthetic firms" from the available data. We also developed a model of insurance markets that simulates

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[13]  For illustrative purposes we use the Blue Cross/Blue Shield "Basic" plan provided under the Federal Employees Health Benefits Program (FEHBP) to estimate benefit costs.

495261

the process of rating health plans, based upon the insurance market rating laws in the 50 states and the District of Columbia.

Our approach was to match each working individual in MEPS to one of the firms in the 2006 Kaiser Family Foundation and the Health Research and Educational Trust (HRET) survey of 2,000 employers, including insuring and non-insuring firms. We statistically matched these plans with a sample of employers in the 1997 Robert Wood Johnson Foundation (RWJF) to provide data on workers characteristics. Workers were assigned to firms that are consistent with the demographic and income characteristics of the employer's workforce.[14] We then "populated" each firm that an individual is matched to by randomly assigning additional MEPS workers to the firm who match the firm's workforce characteristics. This provided complete employer units with all of the information required to simulate employer decisions.

The employer tax credit was modeled assuming that it will be treated by employers as a reduction in the price of insurance. We estimated the number of non-insuring firms that respond by offering coverage based upon a Lewin multivariate analysis of how the percentage of employers offering coverage changes as the price of insurance changes. As shown in *Figure A-3*, for firms with 10 or fewer workers, a 1 percent reduction in premiums is associated with a 0.87 percent increase in the number of employers offering coverage. It also shows that the price response for employers declines rapidly as firm size increases, and that there is very little price response in the largest firm size groups.

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[14] The Kaiser/HRET data provide information on the distribution of workers by wage level only. We statistically matched the Kaiser/HRET data with employers surveyed in the 1991 Health Insurance Association of America (HIAA) employer survey data, which provides detailed information on the characteristics of each employer's workforce including number of workers by part-time/full-time status, age, gender, medical policy type and the coverage/eligibility status of employees.

495261
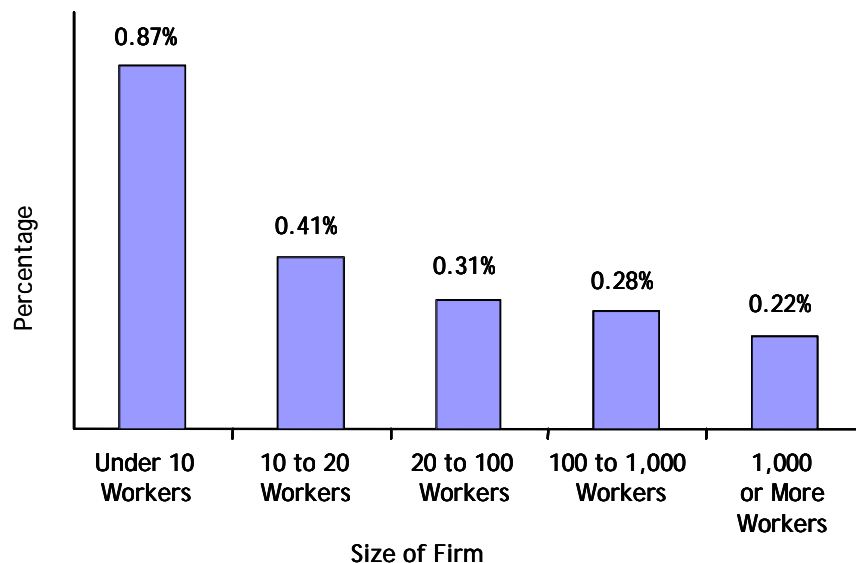
Source:   The Lewin Group estimates.

We also used these data to estimate the impact of the various elements of Bill that would reduce employer health insurance premiums including the employer tax credit and the reduced premiums under the public plan. These features would generally reduce the cost of employer insurance. We simulated the impact of these changes in premiums on the number of employers offering insurance based upon the price response assumptions shown in *Figure A-3*.

The model reflects variations in firm price elasticity depending upon the characteristics of the firm. For example, the model shows that the firm price elasticity tends to decline as age and income rise, as shown in *Figures A-4* and *A-5*. This results in a lower estimated price elasticity among currently insuring firms -- averaging about -0.56 for firms with 10 or fewer workers -- because the employers that offer coverage tend to have older and more highly compensated workers.

In addition, we estimated multivariate models predicting the percentage of the premium paid by the worker using the RWJF employer data. These equations measure how premium shares vary with the characteristics of the firm, their workforce and the amount of the total premium. These amounts are used to estimate the cost of insurance for workers in each firm selected to offer coverage in response to the program.

Once firms are selected to offer coverage, we simulate enrollment among workers assigned to these plans. The enrollment decision is simulated with a multivariate model of the likelihood that eligible workers will take the coverage offered to them based upon data reported in the 1996 MEPS data for people offered coverage through an employer. The model measures how take-up varies with the characteristics of the individual as well as the employee premium contribution required by the employer.

**Figure A-4**
**Employer Health Insurance Price Elasticity Estimates for Firms with Under 10 Workers by Average Wages and Salaries per Worker** [a/]
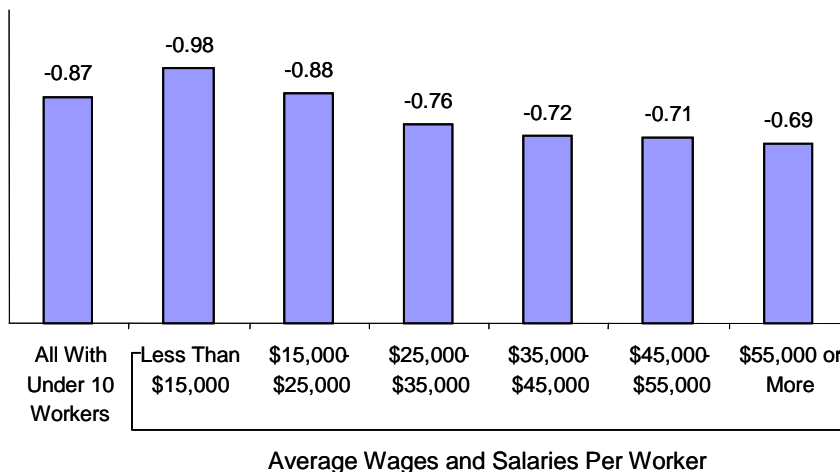


**Average Wages and Salaries Per Worker**

a/ Based upon multivariate analysis of the 1997 Robert Wood Johnson Foundation (RWJF) Survey of Employer Characteristics. "Health Benefits Simulation Model (HBSM)," The Lewin Group, August 2003.

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

**Figure A-5**
**Employer Health Insurance Price Elasticity Estimates for Firms with Under 10 Workers**
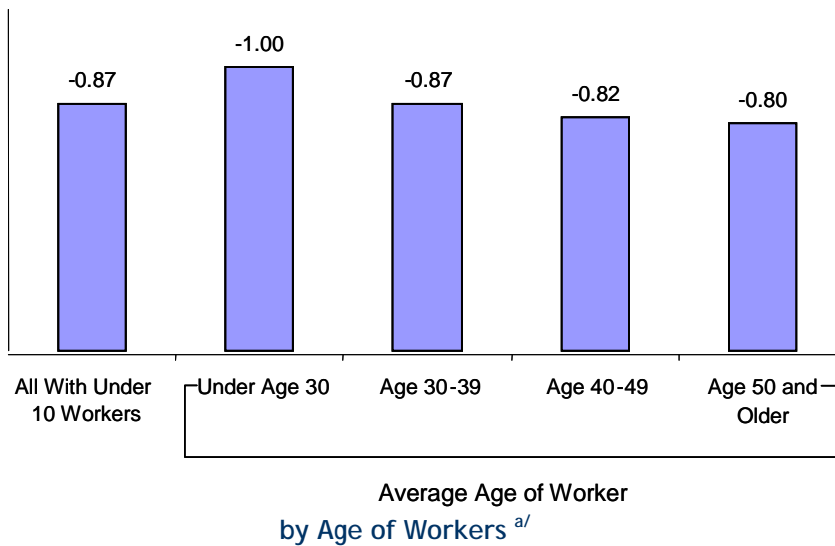


**Average Age of Worker**
**by Age of Workers** [a/]

a/ Based upon multivariate analysis of the 1997 Robert Wood Johnson Foundation (RWJF) Survey of Employer Characteristics. "Health Benefits Simulation Model (HBSM)," The Lewin Group, August 2003.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

495261

Finally, based upon a review of the economic literature, we assume that changes in employer costs resulting from these proposals would be passed on to workers in the form of changes in wage growth over time. For example, policies that reduce employer costs would result in a corresponding increase in wages for affected workers. Similarly, increases in employer health benefits costs are assumed to be passed on to workers as wage increases.[15]  HBSM also simulates the impact of these changes in wages upon federal and state tax revenues.

## E. Simulating Effects for Individuals and Self-employed

We simulate the individual's decision to enroll in the public plan by estimating the premium that these individuals would pay in the current private market for the benefits offered in the public pool. The public plan could increase coverage if it provides coverage to uninsured people at a lower cost than in the current market. This can also result in shifts in coverage from existing sources to the public plan.

### 1. Simulating Changes in Number with Coverage

We begin by estimating the program's effect on the number of people with coverage. We first identify uninsured people who would now be able to purchase coverage at a lower price than they would pay in the individual market under current law. We interpret this as a reduction in premiums that will cause some people to take coverage. We simulate their decision to take that coverage using research on how changes in premiums affect the likelihood of taking coverage. We assume that newly insured people will enroll in whichever coverage option is least costly.

In the next step, we identify currently insured people who would now face a higher premium. This would occur in cases where the availability of the public plan is coupled with changes in insurer rating regulations affecting the premiums in both the private market and the public plan. For example, the Obama proposal would prohibit medical underwriting, which will generally increase premiums for relatively healthy individuals now covered in the individual market. We also simulate losses of coverage for these people using the same research on how price affects the individual's decision to take coverage.

### 2. Allocation to Public and Private Coverage

In this step, we identify privately insured people who would be eligible to purchase coverage at a lower cost through the public plan. We then simulate their decision to shift to the public plan based upon studies of how people respond to changes in the relative price of insurance within employer groups offering a choice of health plans.[16] We simulate these shifts in a two step process that allocates affected people into one of the following three groups:

- People who remain with their current private health plan rather than shifting to the public plan;

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[15]  Marginal tax rates are imputed to the MEPS household data based upon the tax rate data collected in the CPS data.

[16]  Strombom, B., Buchmueller, T., Feldstein, P. "Switching Costs, Price Sensitivity and Health Plan Choice," *Journal of Health Economics*, 21 (2002), 89-116.

- People who drop private coverage to enroll in the public plan due to the lower premiums; and

- People who leave the public plan to enroll in a lower cost HMO.

In the first step, we model the shift of privately insured individuals to the lower cost public plan. We do this using "plan change price elasticity" estimates developed by Strombom et al., which averages about -2.47. This means that on average, a 1.0 percent decrease in the price of an alternative source of coverage is associated with a 2.47 percent migration of enrollees to the lower cost health plan. As shown in *Figure A-6*, the likelihood of shifting to a lower cost plan is lowest for older and sicker people, reflecting that these groups are typically less willing to change providers. Individuals were randomly selected to shift to an HMO based upon these price changes and these price elasticity estimates.[17]

Figure A-6
Health Plan Change Price Elasticity Assumptions by Age and Health Risk

| | All Insured Groups | | HMOs Only | |
|---|---|---|---|---|
| | Low Risk | High Risk [a/] | Low Risk | High Risk [a/] |
| Under 31 | -5.8 | -5.3 | -7.0 | -8.0 |
| 31 – 45 | -3.9 | -3.6 | -5.9 | -6.4 |
| Over 45 | -2.4 | -2.1 | -4.3 | -4.5 |

a/ The study defines high risk people as those who have selected illness or hospitalizations. In our model, as a proxy for this definition, we assumed that people with expected spending in excess of the 80th percentile of spending are "high risk".
Source: Strombom, B., Buchmueller, T.,Feldstein, P. "Switching Costs, Price Sensitivity and Health Plan Choice," *Journal of Health Economics* 21 (2002) 89-116.

These estimates are consistent with other studies showing that people leaving fee-for-service (FFS) health plans for HMOs and other managed care plans tend to have lower costs than those who remain with these FFS plans. Similarly, people who leave HMOs for a FFS plan tend to have higher costs than those who remain with the HMO.[18]

In the second step we model risk selection against the public plan. Some managed care plans would develop products that tend to attract younger and healthier people through benefits design or marketing practice. This will tend to leave the public plan with higher cost individuals. We simulate this by assuming that private HMOs are able to offer a product that is four percent less costly than the premium for the public plan. This assumption is based upon research showing that utilization of health services in HMOs is about four percent less than in PPO and other FFS plans.

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[17] Newly insured people were randomly assigned to HMOs based upon the percentage of privately insured people who are in HMOs after we have executed our simulation for currently insured people.

[18] David M. Cutler and Richard J. Zeckhauser, "Adverse Selection in Health Insurance," National Bureau of Economic Research, working paper 6107, July 1997; and Paolo Belli, "How Adverse Selection Affects the Health Insurance Market," Harvard School of Public Health.

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We simulate the shift of individuals from the public plan to these HMOs using the plan change price elasticity estimates presented above in *Figure A-6*. This approach tends to leave higher cost individuals in the public plan, with lower cost individuals shifting to HMOs.

## F.  Simulating Effects for Employers

Under the public plan scenarios presented above, some or all employers would have the option of covering their workers under the public plan by paying a premium. In some cases, non-insuring employers would start to offer coverage in response to the lower premium available in the public plan. Also, many currently insuring employers will shift to the public plan to take advantage of the lower public plan premium. The approach we use to simulate the impact of the public plan on employer coverage is similar to that used to simulate coverage decisions in the individual market.

### 1.  Simulate Changes in the Number of Employers Offering Coverage

We first identify non-insuring employers who would now be able to purchase coverage at a lower price than they would pay in the current insurance market. We simulate their decision to take that coverage due to the price reduction using studies of how changes in premiums affect the likelihood that a firm will offer coverage. We assume that newly insured people will enroll in whichever coverage option is least costly.

In the next step, we identify firms that would now face a higher premium. Under the Obama-like health reform proposal modeled here, the elimination of medical underwriting would increase premiums for younger and healthier groups while reducing premiums for older and sicker groups. We simulate losses of coverage for these people using the studies of the effect of changes in premiums on the firm decision to offer insurance.

### 2.  Re-allocation to Public Plan

In this stage, we identify privately insured firms that would be eligible to purchase coverage at a lower cost through the public plan. We simulate these shifts in a two step process that allocates affected people into one of the following three groups:

- Employers that remain with their current private health plan rather than shifting to the public plan. (These will tend to include employers with older and less healthy workers who decide not to change their source of coverage, perhaps to retain their current physician);

- Employers that drop private coverage to enroll in the public plan due to the lower premium; and

- Employers that leave the public plan to enroll in a lower cost HMO.

In the first step, we simulate the employer decision to switch to the lower cost public plan based upon the plan change price elasticity estimates used in our individual market simulations (see *Figure A-6* above). We do this by estimating the plan change price elasticity for each worker in the firm based upon the age and health status of each worker. We then use this average price

change elasticity for workers in each firm to simulate the employer decision to change their source of coverage.

In the second step we model risk selection against the public plan. We assume that managed care plans would develop products that tend to attract younger and healthier people through benefits design or marketing practice. This will tend to leave the public plan with higher cost individuals. We simulate this by assuming that private HMOs are able to offer a product that is four percent less costly than the premium for the public plan. This assumption is based upon research showing that utilization of health services in HMOs is about four percent less than in PPO and other FFS plans. We simulate the shift of individuals from the public plan to these HMOs using the plan change price elasticity estimates presented above.

This approach tends to leave higher cost individuals in the public plan, with lower cost individuals shifting to HMOs. This accumulation of a disproportionate share of higher cost individuals in a given plan is called "adverse selection."

495261