Cost Estimates for a PPACA Replacement Plan

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The Patient Protection and Affordable Care Act (PPACA) has now survived legislative, judicial, and electoral challenges. Those apparent successes notwithstanding, the PPACA remains a sweeping – and damaging – reform of the health care delivery, health entitlements, and health insurance sectors in the United States. Its policy flaws are myriad. With its most significant provisions scheduled to take effect in 2014, advocates for an alternative reform have two apparent options: repeal and replace the PPACA when the time is right, or undertake sequential reforms intended to improve its policy outcomes. Of course, in the current political context, neither appears promising. Nevertheless, there is merit to continued evaluation of full-scale alternatives to the PPACA. One common defense of the law is that there has been no competing alternative, which is not true. But there is virtue to continuing to develop and refine as many alternatives as may be proposed. Toward that end, this short paper outlines one practical, conservative approach to replacing the law with a market-based reform plan.

It is important that the alternatives and the PPACA be evaluated on a level playing field with respect to the estimated impact on the federal budget, premiums, the uninsured and other empirical aspects of the impacts of reform. Naturally, these estimates depend largely on economic simulation models. When the Congressional Budget Office analyzes reform proposals, its estimates are the center of the policy debate. Its estimates are, in turn, heavily influenced by the modeling choices it makes. To compare the PPACA and our alternative, we provide an alternative approach developed by the American Action Forum, using the Health Economic Policy Simulation System (HEPSS), to analyze the impact of this replacement plan on key metrics of policy interest.

"Substitute" policy proposals are useful to the extent that they can be thoroughly evaluated on the basis of these impacts, and compared to the PPACA's associated projections. In an effort to offer as many responsible routes to healthcare cost reduction and market improvement as possible, the following proposal describes a practical set of policy choices and associated projections.

The PPACA Replacement Plan

The replacement plan is a decentralized, market-driven alternative to the PPACA. The plan is built on more flexible insurance rules, state authority, and consumer incentives. The key features of the proposal have been described in two separately published papers.[1]

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The main provisions of the replacement plan (assumed to become effective in 2014) are as follows:

- ***Continuous Coverage Protection***: Persons who stay in continuous insurance coverage status would be granted new protection regarding their insurance premiums. Specifically, these persons could move between insurance platforms (employer, individually-owned, public) without the fear of facing risk-rated premium increases. They could only be charged standard rates by the insurers. There would be an initial "open enrollment season" for the uninsured to enroll in insurance and secure this protection going forward. An open season would also be scheduled every five years. This protection would be enacted in federal law and implemented by the states. States would set the insurance rules for persons not in continuous coverage.

- ***Tax Credits for Coverage***: Households not enrolled in employer-based insurance would be eligible for a tax credit for private insurance coverage. The amounts of the credit would initially be set at $5,000 for family coverage and $2,500 for individual coverage and indexed thereafter.

- ***State Regulation of Benefits and Insurance***. The states, not the federal government, would establish the rules for required insurance benefits and other insurance parameters (such as a age-rating of insurance). The only federal requirement would be that insurance plans eligible to be purchased with federal tax credits must have catastrophic insurance protection for enrollees (an out of pocket limit); otherwise, benefit design will be entirely up to insurers within the boundaries of state regulation.

- ***Default Plans***: Persons eligible for tax credits who fail to make an overt insurance selection would be assigned to a default plan by the states. The premium for default plans would be exactly equal to the federal credit, as insurers would be allowed to adjust the up-front insurance deductible as necessary to ensure the premium did not exceed the credit. States would designate numerous default plans and the assignment of the beneficiaries would be done on a random basis. Persons assigned to a default plan would be allowed to disenroll from the default insurance at any time and either enroll in another plan or go without insurance altogether.

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[1] See "How to Replace Obamacare," James C. Capretta and Robert E. Moffit, *National Affairs*, Spring 2012 (http://www.nationalaffairs.com/publications/detail/how-to-replace-obamacare) and "Constructing an Alternative to Obamacare: Key Details for a Practical Replacement Program," James C. Capretta, American Enterprise Institute, Health Policy Outlook No. 6, December 2012 (http://www.aei.org/files/2012/12/12/-constructing-an-alternative-to-obamacare-key-details-for-a-practical-replacement-program_171532844111.pdf)

- ***Medicaid Reform***: The Medicaid program would be substantially reformed. For the non-elderly and non-disabled, Medicaid eligible families would first get the new federal tax credit for insurance. States would then use Medicaid to supplement the tax credit to make coverage even more affordable for the lowest income households. The federal share of the revised Medicaid program would be adjusted so that combined federal costs from the credits and the Medicaid program equal what would have been spent federally without the reform.

- ***Tax Limitation***. Those enrolled in employer plans would retain those plans under the reform and not migrate into the tax credit-eligible population. However, the tax preference for employer-paid health insurance would be subject to an upper limit, set at a level to generate approximately $100 billion in savings by 2020. We estimate that the limitation would need to be set at about the 70 percentile in terms of premium for existing employer plans to generate that level of savings (roughly $16,000 for family coverage).

- ***Deficit Neutrality***. The proposal would be combined with other cost-saving reforms in the Medicare and Medicaid programs to bring total federal costs down and ensure that the overall proposal reduces, rather than increases, federal spending. These spending reductions are not yet specified but could include a reform of the treatment of secondary insurance in the Medicare program (to prevent first-dollar coverage in unmanaged fee-for-service, including for federal and military retirees), and a reduction in the Medicaid disproportionate share hospital funding in recognition of the movement of large numbers of the uninsured into insured status.

Results

The results of our analysis are encouraging and displayed in Tables 1 and 2. The key findings are as follows:

- *A large reduction in the uninsured*. The assignment of persons eligible for the tax credit who fail to sign up with a plan to a default insurance carrier would substantially reduce the number of uninsured Americans. According to the HEPSS estimates (discussed further below) and as shown in Table 1, the number of uninsured in the U.S. would fall from about 53 million today (under the age of 65) to about 29 million in 2015. That compares very favorably to the CBO estimate of the uninsured under the PPACA, which is 37 million in 2015.[2]

[2] CBO's most recent estimates for the insurance coverage provisions of the PPACA can be found in a table entitled, "CBO's February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," February 5, 2013 (available here: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf).

Table 1: Insurance Status, 2013 to 2015 Population Under Age 65 (Millions)						
	2013			2015		
	CBO Est. PPACA	HEPSS Est. PPACA	HEPSS PPACA Replacement	CBO Est. PPACA	HEPSS Est. PPACA	HEPSS PPACA Replacement
Employer-Sponsored	155	158	155	155	155	157
Individually-Owned	24	25	33	36	39	60
Medicaid	37	35	36	47	44	38
Uninsured	55	53	54	37	36	29
	272	271	278	276	274	283

- *Budgetary Effects*. We estimate that the added costs of providing tax credits would reach about $240 billion in 2020 (the cost of refundable tax credits in excess of tax liabilities for some households are counted as outlays). The PPACA replacement plan partially covers this cost with the revenue raised from placing an upper limit on the tax preference for employer-paid premiums. The rest of the cost would be covered through spending restraint, focused particularly on reforms in the Medicare and Medicaid programs. It is worth noting that the PPACA generated about $120 billion in Medicare and Medicaid savings in 2020.

Table 2: Federal Budgetary Effects	
	$ Billion
	2020
	PPACA Replacement
Credits Net of Revenue Raised from an Upper Limit on the Employer Tax Preference	141
Offsets from Other Medicare and Medicaid Reforms	141

Estimating the Impacts of Health Care Reform

The goals of health care reform are relatively straightforward. The public and their elected leaders want to make progress on controlling costs while at the same time ensuring that more Americans gain insurance coverage and the health system offers high quality health care. And all of this should be achieved while improving, or least not worsening, the budget outlook.

So the goals are clear, but assessing the degree to which a specific legislative proposal makes progress toward these goals, or would instead lead to setbacks, is exceedingly

difficult to do. In the long debate over the passage of the PPACA, judgments on these criteria were key moments in the debate.

Not surprisingly, these judgments were heavily influenced by the best available analytical information on the various reform options, produced by the Congressional Budget Office (CBO). Over several years preceding the 2009-2010 health care debate, CBO built a number of simulation models specifically to assess the impact that various approaches to reform would have on premiums; program participation in Medicaid and Medicare; and private coverage. These, of course, have a huge influence on federal spending and taxes.[3] Thus, these models proved crucially important to the congressional debate.

Among other things, the authors of the PPACA worked closely with the staff at CBO in constructing their proposals. Many of the CBO analyses and cost estimates done on early versions of the PPACA were never seen beyond the offices of those writing the legislation. That's because the authors received the information confidentially from CBO (as is their long-standing practice) and then modified the legislation as much as necessary until they received the kind of estimates they were looking for. In this way, the CBO model was instrumental in shaping the final bill.

Moreover, during debate on the legislation, CBO's numbers became the most important data points used by both sides to make their points both for and against its enactment.

All of this is unavoidable. Health care reform is exceedingly complex public policy, and predicting how a specific proposal will alter the key metrics of policy interest cannot be done without significant expertise. Inevitably, the task must be delegated to experts, and the staff at CBO is certainly that.

And it is also inevitable that CBO's estimates will be treated as "facts," when in reality they are predictions – predictions that may or may not turn out to be accurate. The truth is that the CBO and its models are just that: models. They are subject to any number of errors, most especially about the assumptions that are a part of every model but also from the omission of the unintended and unexpected consequences that every complex law produces. Among other things, the CBO model makes assumptions about future cost growth of premiums. The estimates provided for the PPACA assumed a modest reduction in costs associated with more transparent price competition in the health insurance exchanges.

Given the uncertainty surrounding such predictions, the health reform policy process will be improved, and the debate enriched, by additional sources of information beyond CBO. That way policymakers and the public could see for themselves how different approaches to estimating, as well as different assumptions, can produce different results with respect to insured status, premium increases, and federal spending, taxes, and deficits.

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[3] "CBO's Health Insurance Simulation Model: ATechnical Description," Congressional Budget Office, October 2007 (http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/87xx/doc8712/10-31-healthinsurmodel.pdf).

The estimates provided in this paper are initial projections from the HEPSS model. We plan to continue refine the model and to provide additional analyses as the health reform debate unfolds.

The following is a description of HEPSS.

The Health Economic Policy Simulation System (HEPSS)

The Health Economic Policy Simulation System (HEPPS) is a microsimulation model with the capacity to estimate costs, premiums, and insurance coverage for the U.S. population.

HEPSS has two major components, one dedicated to providing estimates for the population under age 65 and the other for those age 65 and older.

The model predicts consumer responses to insurance enrollment and use of health services based on changes in public policies and the resulting incentives for different segments of the population.

The model is built like other models around coefficients used to estimate how people will respond when presented with various alternative insurance status options. This model is unique, however, in that is relies much more heavily than other models on large employer-originated data sets that contain substantial enrollment in high deductible plans. The model is also calibrated to reflect the impact of consumer incentives for cost effective care on the rise in health spending in future years. The emphasis on robust consumer information is crucial to calibrating the system-wide response to some of the policy options often considered in Congress.[4]

The HEPSS model, and earlier versions of it, has been used to provide estimates to the Department of Health and Human Services, members of the House and Senate, and various other public and private clients over the past several years.

It is AAF's intention to continue to improve and refine the model and use it as an educational resource for on-going health policy debates.

Conclusion

Although the PPACA is now being implemented, there is certain to be on-going debate about the most appropriate course for health care policy in coming years, especially in light of the nation's continuing fiscal challenges. As these debates occur, the quality of the decision-making will be a function, in part, of the estimates of what various policies might mean for insurance coverage, premiums, and the federal budget.

[4] A full description of the model and its specification can be found in Parente, S., R. Feldman, J. Abraham, and Y. Xu, "Consumer Response to a National Marketplace for Individual Health Insurance," *Journal of Risk and Insurance*, 2011.

The HEPSS model is intended to be a resource to help the public and policymakers reach conclusions about what these policies might mean, using an approach to estimating that is entirely independent and not identical to the methods used by CBO.

As noted in this paper, the model projects that an alternative to the PPACA has the potential to provide substantial insurance coverage expansion within a decentralized, market-driven reform framework. There is no need for either individual or employer mandates. That alone should be of interest to the health policy community and can form the basis for a healthy debate in the months and years ahead.