

# CARDIOLOGY GRAND ROUNDS

**Title: Healthcare economics, health technology, and the Affordable Care Act 2017**

**Speaker: Professor Stephen T. Parente, PhD, MPH, MS**

Associate Dean, Professor and Minnesota Insurance Industry Chair  
Carlson School of Management  
University of Minnesota



**Date: Monday, September 12, 2016**

**Time: 7:00 – 8:00 AM**

**Location: Abbott Northwestern Hospital – Wyman Room  
Lower level across from the hospital cafeteria**

**\*\*NEW LOCATION\*\***

## OBJECTIVES

At the completion of this activity, the participants should be able to:

1. Recognize how the 2010 Patient Accountability and Affordable Care Act (aka ACA or Obamacare) is part of a 100+ year arc of health insurance reform that is distinctly an American story.
2. Recognize the key features of future health care reform and their impact on health care delivery and financing.
3. Recall how the American health economy arc will influence global health systems and technology advances in the 21st century.

**Physician:** This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Allina Health and Minneapolis Heart Institute Foundation. Allina Health is accredited by the ACCME to provide continuing medical education for physicians.

Allina Health designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit(s)*<sup>TM</sup>. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

**Nurse:** This activity has been designed to meet the Minnesota Board of Nursing continuing education requirements for 1.2 hours of credit. However, the nurse is responsible for determining whether this activity meets the requirements for acceptable continuing education.

## DISCLOSURE STATEMENTS

**Speaker:** Professor Parente has declared that he does not have any conflicts of interest to disclose.

**Planning Committee:** Dr. JoEllyn Abraham, Dr. Alex Campbell, Dr. Kevin Harris, Rebecca Lindberg, Dr. Michael Miedema, Dr. Scott Sharkey, Eva Zewdie and Jolene Bell Makowsky have declared that they do not have any conflicts of interest associated with the planning of this activity. Dr. David Hurrell declares the following relationship – honoraria: Boston Scientific.

## ACKNOWLEDGMENT OF SUPPORT

This presentation is partially funded by an educational grant from **Health Catalyst**.

**PLEASE SAVE A COPY OF THIS FLIER AS YOUR CERTIFICATE OF ATTENDANCE**

Signature: \_\_\_\_\_

*My signature verifies that I have attended the above stated number of hours of the CME activity.*



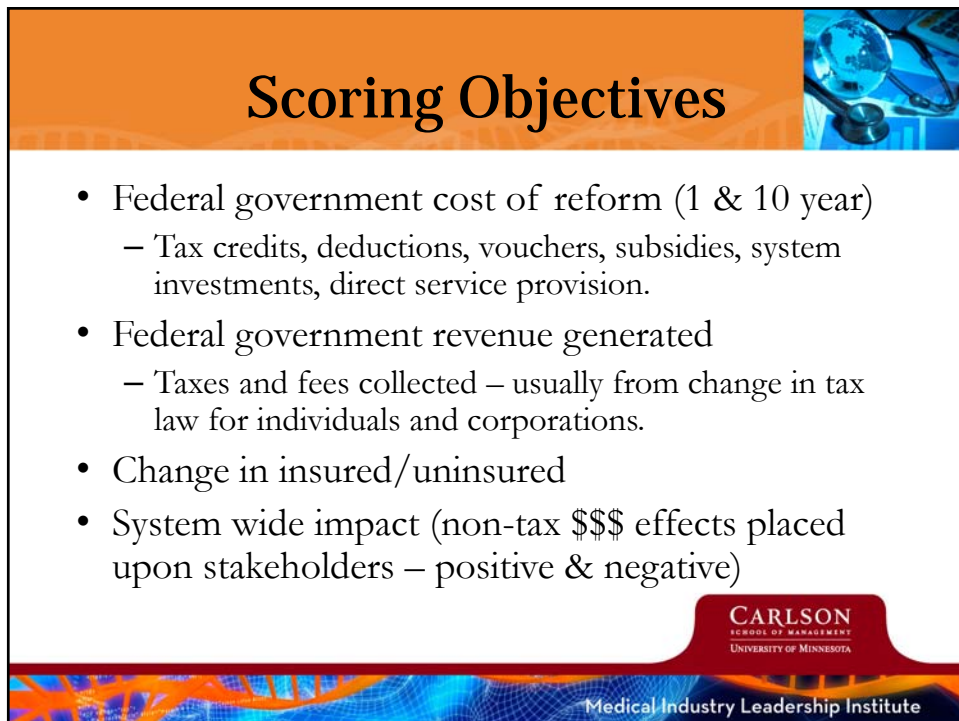
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## Scoring US Health Reform

**Stephen T. Parente, Ph.D.**  
Minnesota Insurance Industry Chair of Health Finance,  
Carlson School of Management Associate Dean of MBA Programs,  
and Director of the Medical Industry Leadership Institute at the University of Minnesota  
Governing Chair, Health Care Cost Institute, Washington, DC  
Board Member, The Center for Health and Economy, Washington, DC

Presentation to Minneapolis Heart Institute Cardiovascular Grand Rounds, Minneapolis, 2016



## Scoring Objectives

- Federal government cost of reform (1 & 10 year)
  - Tax credits, deductions, vouchers, subsidies, system investments, direct service provision.
- Federal government revenue generated
  - Taxes and fees collected – usually from change in tax law for individuals and corporations.
- Change in insured/uninsured
- System wide impact (non-tax \$\$\$ effects placed upon stakeholders – positive & negative)

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## Scoring Challenges



- Inter-related set of factors that play on each over time – dynamic simultaneous equations
- Little true data to be used to predict response from comparable experiments or demonstrations
- Few actual ‘levers’ to test effect based on real data
- Little peer review and few colleagues that are not ‘conflicted’ or ‘private’ or ‘non-transparent’

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## Levers that Matter




- Credits/Deductions/Subsidies
- Insurance Choice Set
- Plan Design
- Premiums in the Real World
- State-specific factors
- Growth rate & inflation
- Income-related points of inflection
- Out of Sample Land - Missing data assumptions



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## Debits (costs) & Credits ('pay-fors')



- DEBITs to Federal Government:
  - Tax credits/vouchers
  - High risk pool subsidies
  - Social insurance (e.g., Medicare & Medicaid)
  - Health IT purchases
- CREDITs to Federal Government:
  - Untaxed employee wage substitute artifact of WWII
  - Tax sin & non-profits
  - Rationing through supply (fee schedules & 'saying no')
  - Rationing through price (remove premium supports)

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## Policy Proposal Simulations



*Impacts simulated by the ARCOLA  
(Adjusted Risk Choice & Outcomes  
Legislative Assessment) model*

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## Policy Levers ARCOLA can Model



- Premium changes from public policy
- Taxes (e.g., Employer Sponsored Insurance Tax Exclusion)
- Subsidies (crude or targeted)
  - Tax credits
  - Vouchers
  - Tax Deductions
- New private and public insurance entry and exit
- ->New-<
  - Provider Access
  - Medical Productivity

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## ARCOLA is Appear in Two Venues: Gown

*The Journal of Risk and Insurance*

© The Journal of Risk and Insurance, 2010, Vol. 00, No. 0, 1-23  
DOI: 10.1111/j.1539-6975.2010.01390.x

### CONSUMER RESPONSE TO A NATIONAL MARKETPLACE FOR INDIVIDUAL HEALTH INSURANCE

Stephen T. Parente  
Roger Feldman  
Jean Abraham  
Yi Xu

#### ABSTRACT

The objective of this analysis is to simulate the difference between national

### Employee Choice of Consumer-Driven Health Insurance in a Multiplan, Multiproduct Setting

Stephen T. Parente, Roger Feldman, and Jon B. Christianson

**Objective.** To determine who chooses a Consumer-Driven Health Plan (CDHP) in a multiplan, multiproduct setting, and, specifically, whether the CDHP attracts the sicker employees in a company's risk pool.

**Study Design.** We estimated a health plan choice equation for employees of the

HEALTH TRACKING

### MARKET WATCH

### Health Savings Accounts: Early Estimates Of National Take-Up

Various subsidies to help people open health savings accounts could greatly reduce the number of uninsured Americans.

by Roger Feldman, Stephen T. Parente, Jean Abraham, Jon B. Christianson, and Ruth Taylor

#### ABSTRACT:

The 2003 Medicare Prescription Drug, Improvement, and Modernization Act provided tax-advantaged health savings accounts (HSAs) for certain high-deductible insurance plans. We predict that MMA could lead to approximately 3.2 million HSA among Americans ages 19-64 who are not students, not enrolled in public insurance plans, and not eligible for group coverage as a dependent. We simulate several additional tax subsidies for HSAs. We predict that the Bush administra-

## ARCOLA is Appear in Two Venues: Town

The collage features three news articles:

- The Wall Street Journal:** "The Short Unhappy Life of ObamaCare" by Stephen T. Parente. Sub-headline: "By 2024 there will be more than 40 million uninsured, roughly 10% more than in 2010." The article discusses the impact of the ACA on the insurance market.
- StarTribune:** "The ACA in action: Trending toward terrible, with higher bills, fewer covered" by Stephen T. Parente. Sub-headline: "Growth in premiums, unmitigated by subsidies, will lead to dropouts." The article notes that roughly 60,000 people purchased health insurance on the state's ACA online exchange last year, a decrease from the previous year.
- Politico:** "A grand health bargain that cuts debt" by an opinion contributor. The article discusses a potential deal between the administration and Congress to reduce the deficit through health care reforms.

## 2016 Proposals Scored

1. Senator Sanders Plan
2. Entertainer & Developer Trump Plan (v1)
3. Presidential Candidate Trump Plan (v2)
4. Speaker Ryan's Better Way Plan

# 1) Senator Sanders 2016 Presidential Campaign Proposal



**Center for Health and Economy**

About Models Legislative Analyses Analyses Contact

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## Medicare for All: Leaving No One Behind

Posted on May 1, 2016 by Admin in Analyses

Presidential candidate Bernie Sanders has designed a replacement for the Affordable Care Act (ACA), called "Medicare for All: Leaving No One Behind." The replacement, referred to in this report as the Plan, is a proposal for a single-payer health program that is managed by the federal government with the goal of universal coverage. This report details the findings of the Center for Health and Economy's (H&E) Under-65 Microsimulation Model on the proposal's impact on health insurance coverage, provider access, medical productivity, and the federal budget. While our estimates are associated with some degree of uncertainty, the summary of our findings is as follows.

**KEY FINDINGS:**

- Without the need to sign up for insurance H&E assumes universal coverage.
- Under the Plan, medical productivity is projected to decrease by 20 percent for the year 2026 relative to the current baseline due to the massive increase of patients into the health system.
- Provider access is projected to increase by 19 percent by 2026 as a result of the universal coverage, along with the elimination of cost sharing.

**Recent Posts**

- A Better Way to Fix Health Care
- Healthcare Reform to Make America Great Again
- Employer Exclusion Cap Revenue and Enrollment Effects
- Medicare for All: Leaving No One Behind
- Health and Economy Baseline Estimates

**Categories**

- Analyses
- Legislative Analyses
- Uncategorized
- What We're Reading

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# 1) Senator Sanders 2016 Presidential Campaign Proposal



- Assumptions:
  - Everyone mostly shifts to medium PPOs with Actuarial Value 80%
  - Some people still in Medicaid.
  - Federal government funds the entirety of the premium and there are no uninsured.
  - Spending is (barely) muted by closing the ESI tax exclusion.

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# 1) Senator Sanders 2016 Presidential Campaign Proposal



Table 1. Health Insurance Coverage (millions)

	2017	2018	2019	2020	2021	2022	2023	2024	2025
Individual Market	69	70	70	70	71	71	71	72	72
Subsidized Insurance	7	7	7	7	7	7	7	7	7
Other Non-group Insurance	62	63	63	63	64	64	64	64	65
Employer Sponsored Insurance	159	159	160	160	160	160	161	160	160
Medicaid	42	42	43	43	43	43	44	44	44
Other Public Insurance <sup>2</sup>	4	4	5	5	6	6	7	8	9
<b>Total Non-Elderly Population</b>	<b>274</b>	<b>275</b>	<b>277</b>	<b>278</b>	<b>280</b>	<b>281</b>	<b>282</b>	<b>284</b>	<b>285</b>
<b>Total Insured<sup>1</sup></b>	<b>274</b>	<b>275</b>	<b>277</b>	<b>278</b>	<b>280</b>	<b>281</b>	<b>282</b>	<b>284</b>	<b>285</b>
<b>Uninsured<sup>1</sup></b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

<sup>1</sup> All insurance coverage estimates refer only to the under-65 population.

<sup>2</sup> Other Public Insurance includes under-65 Medicare enrollment.

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# 1) Senator Sanders 2016 Presidential Campaign Proposal



Table 6. Cost of Coverage Provisions (billions)<sup>1</sup>

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016 - 2025
<b>Sources of Funds<sup>2</sup></b>										
Employer Sponsored Insurance	-1,881	-1,997	-2,092	-2,191	-2,294	-2,400	-2,508	-2,627	-2,741	-20,732
Individual and Employer Mandate Taxes	0	0	0	0	0	0	0	0	0	0
<b>Subtotal</b>	<b>-1,881</b>	<b>-1,997</b>	<b>-2,092</b>	<b>-2,191</b>	<b>-2,294</b>	<b>-2,400</b>	<b>-2,508</b>	<b>-2,627</b>	<b>-2,741</b>	<b>-20,732</b>
<b>Uses of Funds<sup>3</sup></b>										
Health Insurance Marketplace Cost Sharing Benefits	0	0	0	0	0	0	0	0	0	0
Premium Tax Credits	714	761	810	862	918	978	1,041	1,108	1,180	8,372
Medicaid	296	312	329	346	366	388	412	438	468	3,355
Medicare	0	0	0	0	0	0	0	0	0	0
<b>Subtotal</b>	<b>1,011</b>	<b>1,073</b>	<b>1,138</b>	<b>1,209</b>	<b>1,284</b>	<b>1,365</b>	<b>1,453</b>	<b>1,547</b>	<b>1,648</b>	<b>11,727</b>
<b>Net Budgetary Impact<sup>4</sup></b>	<b>-2,891</b>	<b>-3,069</b>	<b>-3,231</b>	<b>-3,400</b>	<b>-3,579</b>	<b>-3,766</b>	<b>-3,961</b>	<b>-4,174</b>	<b>-4,389</b>	<b>-32,459</b>

<sup>1</sup> Cost estimates refer only for the under-65 population.

<sup>2</sup> Positive values denote increases in revenue; negative values denote decreases in revenue.

<sup>3</sup> Positive values denote increases in spending; negative values denote decreases in spending.

<sup>4</sup> Positive values denote surplus; negative values denote deficit.

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## 2) Trump's Fabulous (pre-March 2016) Presidential Campaign Proposal



- Assumptions:
  - Single Payer Advocate
  - Still wants everyone to have choice of Doctor if they can afford it.
  - Thus, everyone is in either Medicaid or an HDHP.
  - Individual market HDHP had a better price in our model,
  - Assume shifted of entire ESI market to the individual HDHP plans.
  - Significant revenue gained from closing the ESI tax exclusion.

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## 2) Trump's Fabulous (pre-March 2016) Presidential Campaign Proposal



Table 1. Health Insurance Coverage (millions)

	2017	2018	2019	2020	2021	2022	2023	2024	2025
Individual Market	69	70	70	70	71	71	71	72	72
Subsidized Insurance	7	7	7	7	7	7	7	7	7
Other Non-group Insurance	62	63	63	63	64	64	64	64	65
Employer Sponsored Insurance	159	159	160	160	160	160	161	160	160
Medicaid	42	42	43	43	43	43	44	44	44
Other Public Insurance <sup>2</sup>	4	4	5	5	6	6	7	8	9
<b>Total Non-Elderly Population</b>	<b>274</b>	<b>275</b>	<b>277</b>	<b>278</b>	<b>280</b>	<b>281</b>	<b>282</b>	<b>284</b>	<b>285</b>
<b>Total Insured<sup>1</sup></b>	<b>274</b>	<b>275</b>	<b>277</b>	<b>278</b>	<b>280</b>	<b>281</b>	<b>282</b>	<b>284</b>	<b>285</b>
<b>Uninsured<sup>1</sup></b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

<sup>1</sup> All insurance coverage estimates refer only to the under-65 population.

<sup>2</sup> Other Public Insurance includes under-65 Medicare enrollment.

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## 2) Trump's Fabulous (pre-March 2016) Presidential Campaign Proposal



Table 6. Cost of Coverage Provisions (billions)<sup>1</sup>

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016 - 2025
<b>Sources of Funds<sup>2</sup></b>										
Tax Expenditure on Employer Sponsored Health Insurance	379	363	372	380	389	398	407	419	428	3,535
Individual and Employer Mandate Taxes	0	0	0	0	0	0	0	0	0	0
<b>Subtotal</b>	<b>379</b>	<b>363</b>	<b>372</b>	<b>380</b>	<b>389</b>	<b>398</b>	<b>407</b>	<b>419</b>	<b>428</b>	<b>3,535</b>
<b>Uses of Funds<sup>3</sup></b>										
Health Insurance Marketplace										
Cost Sharing Benefits	0	0	0	0	0	0	0	0	0	0
Premium Tax Credits	2,421	2,503	2,588	2,676	2,767	2,860	2,957	3,057	3,160	24,989
Medicaid	237	248	259	271	283	296	310	324	338	2,567
Medicare	0	0	0	0	0	0	0	0	0	0
<b>Subtotal</b>	<b>2,658</b>	<b>2,751</b>	<b>2,847</b>	<b>2,947</b>	<b>3,050</b>	<b>3,156</b>	<b>3,267</b>	<b>3,380</b>	<b>3,498</b>	<b>27,555</b>
<b>Net Budgetary Impact<sup>4</sup></b>	<b>-2,279</b>	<b>-2,388</b>	<b>-2,476</b>	<b>-2,566</b>	<b>-2,661</b>	<b>-2,759</b>	<b>-2,859</b>	<b>-2,961</b>	<b>-3,071</b>	<b>-24,020</b>

<sup>1</sup> Cost estimates refer only for the under-65 population.

<sup>2</sup> Positive values denote increases in revenue; negative values denote decreases in revenue.

<sup>3</sup> Positive values denote increases in spending; negative values denote decreases in spending.

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## Comparing Bernie and The Donald (v1)



- Everybody covered.
  - Socialist dream
  - Populist dream
- Bernie has more moral hazard. Doubles down on inefficiency of fee-for-service combined with low cost sharing.
- Trump (Version 1.0) is cheaper because of more high deductible plan use. Patients get access to who they want, but at the cost of high deductible – which mitigates a significant amount of moral hazard.

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### 3) Trump's Fabulous (post-March 2016) Presidential Campaign Proposal



- Assumptions:
  - The Affordable Care Act is fully repealed.
  - Individual states' regulatory structures rewind to pre-ACA regulations. States that had guaranteed issue and community rating regulations on insurance without the ACA will still have those regulations.
  - Individuals are allowed to fully deduct health insurance premium payments from their tax returns.
  - Medicaid funding to the states is block-granted. For modeling purposes, assumes historical Medicaid spending as the base amount of grant.

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### 3) Trump's Fabulous (post-March 2016) Presidential Campaign Proposal



Table 3. Health Insurance Coverage Under the Proposal (millions)<sup>2</sup>

	2017	2018	2019	2020	2021	2022	2026
Individual Market	38	37	37	36	36	35	34
Employer Sponsored Insurance	143	143	143	144	144	144	143
Medicaid	33	33	33	34	34	34	35
Other Public Insurance	11	11	12	12	13	14	17
<b>Total Population<sup>3</sup></b>	<b>273</b>	<b>274</b>	<b>275</b>	<b>277</b>	<b>280</b>	<b>281</b>	<b>285</b>
<b>Total Insured<sup>9</sup></b>	<b>225</b>	<b>225</b>	<b>225</b>	<b>226</b>	<b>227</b>	<b>227</b>	<b>229</b>
<b>Uninsured</b>	<b>48</b>	<b>49</b>	<b>50</b>	<b>51</b>	<b>52</b>	<b>53</b>	<b>57</b>

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### 3) Trump's Fabulous (post-March 2016) Presidential Campaign Proposal



Table 4. Change in Insurance Coverage Under the Proposal (millions)<sup>9</sup>

	2017	2018	2019	2020	2021	2022	2026
Individual Market	2	4	5	5	7	7	7
Employer Sponsored Insurance	-2	-2	-2	-1	-1	-1	-1
Medicaid	-18	-18	-18	-18	-18	-18	-18
Other Public Insurance	1	0	0	0	0	1	1
<b>Total Insured<sup>10</sup></b>	<b>-16</b>	<b>-15</b>	<b>-15</b>	<b>-13</b>	<b>-12</b>	<b>-12</b>	<b>-11</b>

<sup>2</sup> All insurance coverage estimates refer only to the under-65 population.

<sup>3</sup> Total enrollment estimates may not equal the sum of all other enrollment due to rounding.

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### 3) Trump's Fabulous (post-March 2016) Presidential Campaign Proposal



Table 9. Budgetary Impact of the Proposal (billions)<sup>9</sup>

	2017	2018	2019	2020	2021	2026	10-Year Total
<b>Sources of Funds<sup>6</sup></b>							
Tax on Employer Sponsored Health Insurance	0	0	0	-19	-20	-16	-132
Individual and Employer Mandate Taxes	-11	-13	-15	-17	-19	-37	-219
Loss of Individual Market Tax Revenue	-46	-44	-43	-41	-40	-32	-390
<b>Subtotal</b>	<b>-57</b>	<b>-57</b>	<b>-58</b>	<b>-77</b>	<b>-79</b>	<b>-85</b>	<b>-741</b>
<b>Uses of Funds<sup>7</sup></b>							
Cost Sharing Benefits	-15	-14	-14	-13	-12	-5	-105
Premium Tax Credits	-77	-79	-81	-81	-82	-93	-835
Medicaid	-48	-49	-49	-48	-49	-55	-504
Other Public Health Insurance	12	3	4	4	6	13	76
<b>Subtotal</b>	<b>-128</b>	<b>-138</b>	<b>-140</b>	<b>-138</b>	<b>-137</b>	<b>-140</b>	<b>-1,368</b>
<b>Net Budgetary Impact</b>	<b>-72</b>	<b>-81</b>	<b>-82</b>	<b>-63</b>	<b>-60</b>	<b>-54</b>	<b>-629</b>

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#### 4) Speaker Paul Ryan's Better Way Plan



- Features

- Premium tax credits,
- Incentives to strengthen HSAs
- Medicaid reform
- Replacement for the Cadillac tax.
- Traditional Medicare reformed and made to compete with Medicare Advantage in 2023

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#### 4) Speaker Paul Ryan's Better Way Plan



- **Coverage Impact:** The Plan is projected to lead to 1 million more insured individuals in 2018 relative to the current baseline. By 2026, this number is expected to be 4 million fewer than under current law, with the decrease concentrated in the Medicaid population.
- **Premium Impact:** The Plan is projected to decrease the premium cost of private health insurance coverage, with the largest impact on Silver, Gold, and catastrophic coverage plans.
- **Medical Productivity:** Under the Plan, medical productivity is projected to increase by 7 percent by the year 2026 relative to the current baseline.
- **Provider Access:** Provider access under the Plan is projected to increase by 4 percent by 2026 relative to the current baseline.
- **Budget Impact:** Compared to current law, the Plan is estimated to decrease the federal deficit by \$481 billion between 2017 and 2026.

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## 4) Speaker Paul Ryan's Better Way Plan



### Change in Coverage Estimates (millions)

	2017	2018	2019	2020	2021	2026
Individual Market	0	2	10	10	12	13
Health Insurance Marketplace	0	-17	-16	-15	-14	-12
Other Non-group Insurance	0	19	26	26	26	25
Employer Sponsored Insurance	0	-1	0	0	0	0
Medicaid	0	-1	-10	-12	-14	-18
Other Public Insurance	0	-1	-2	-1	-1	1
<b>March 2016 Baseline<sup>1</sup></b>	<b>241</b>	<b>240</b>	<b>240</b>	<b>239</b>	<b>239</b>	<b>240</b>
<b>A Better Way</b>	<b>241</b>	<b>241</b>	<b>237</b>	<b>237</b>	<b>236</b>	<b>236</b>

<sup>1</sup> All insurance coverage estimates refer only to the under-65 population.  
<sup>2</sup> This category also includes small changes in other public insurance enrollment.



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## 4) Speaker Paul Ryan's Better Way Plan



### Change in Premiums From Current Law

		2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Single Coverage	90% AV	0%	0%	0%	-6%	-5%	-5%	-5%	-6%	-5%	-5%	-5%	-6%
	80% AV	0%	0%	0%	-2%	-2%	-2%	-2%	-2%	-2%	-3%	-3%	-3%
	70% AV	0%	0%	0%	-3%	-3%	-3%	0%	-2%	0%	-2%	-2%	-2%
	60% AV	0%	0%	0%	-4%	-7%	-7%	-7%	-6%	-3%	-6%	-6%	-6%
	Catastrophic	0%	0%	0%	-58%	-58%	-60%	-57%	-57%	-59%	-61%	-61%	-58%
Family Coverage <sup>1</sup>	90% AV	0%	0%	0%	-9%	-9%	-9%	-9%	-9%	-10%	-9%	-10%	-10%
	80% AV	0%	0%	0%	-9%	-9%	-9%	-9%	-9%	-9%	-9%	-9%	-10%
	70% AV	0%	0%	0%	-8%	-7%	-7%	-7%	-8%	-8%	-8%	-9%	-9%
	60% AV	0%	0%	0%	-11%	-11%	-11%	-11%	-12%	-12%	-12%	-12%	-12%
	Catastrophic	0%	0%	0%	-55%	-56%	-56%	-56%	-56%	-55%	-57%	-57%	-57%

<sup>1</sup> Family coverage estimates are based on a family size of four people.

AV=Actuarial Value

### Average Premiums in the Individual Market

		2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Single Coverage	90% AV	4,700	4,800	5,000	5,000	5,300	5,600	6,000	6,300	6,700	7,100	7,500	7,900
	80% AV	3,700	3,800	3,900	4,000	4,300	4,500	4,800	5,100	5,400	5,700	6,000	6,400
	70% AV	3,100	3,200	3,200	3,400	3,600	3,800	4,100	4,300	4,600	4,800	5,100	5,400
	60% AV	2,200	2,600	2,500	2,600	2,600	2,700	2,800	2,900	3,000	3,000	3,100	3,200
	Catastrophic	1,600	1,700	1,700	800	800	800	900	900	900	900	900	1,000
Family Coverage <sup>1</sup>	90% AV	18,400	19,400	20,400	19,600	20,800	22,000	23,400	24,800	26,200	27,800	29,500	31,200
	80% AV	14,600	15,600	16,400	15,900	16,900	17,900	19,000	20,100	21,300	22,600	23,900	25,300
	70% AV	12,200	12,900	13,600	13,500	14,400	15,200	16,100	17,100	18,100	19,200	20,300	21,500
	60% AV	9,600	10,700	10,900	10,200	10,500	10,800	11,100	11,400	11,700	12,100	12,400	12,800
	Catastrophic	6,100	6,300	6,500	2,900	2,900	3,000	3,100	3,200	3,300	3,300	3,400	3,500

<sup>1</sup> Family coverage estimates are based on a family size of four people.

AV=Actuarial Value



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## 4) Speaker Paul Ryan's Better Way Plan



Table 10. Change in Budgetary Impact Estimates (billions)<sup>1</sup>

	2017	2018	2019	2020	2021	2026	2017-2026
<b>Change in Sources of Funds Baseline Estimates<sup>2</sup></b>							
Tax on Employer Sponsored Health Insurance	0	11	12	-6	-7	-1	-10
Individual and Employer Mandate Taxes	0	-13	-15	-17	-19	-37	-208
<b>Subtotal</b>	<b>0</b>	<b>-2</b>	<b>-3</b>	<b>-23</b>	<b>-26</b>	<b>-38</b>	<b>-218</b>
<b>Change in Uses of Funds Baseline Estimates<sup>3</sup></b>							
Cost Sharing Benefits	0	-14	-14	-13	-12	-5	-90
Premium Tax Credits	0	2	44	45	45	43	360
Medicaid	0	-18	-55	-60	-67	-95	-636
Other Public Insurance	0	-7	-15	-10	-2	17	26
Over-65 Medicare (see Table 11)	0	0	0	-29	-33	-61	-306
Medical Malpractice Reform	0	-6	-7	-8	-8	-10	-77
High Risk Pools	0	2	3	3	3	3	25
<b>Subtotal</b>	<b>0</b>	<b>-41</b>	<b>-45</b>	<b>-81</b>	<b>-78</b>	<b>-88</b>	<b>-699</b>
<b>Net Budgetary Impact<sup>4</sup></b>	<b>0</b>	<b>39</b>	<b>42</b>	<b>49</b>	<b>49</b>	<b>71</b>	<b>481</b>

<sup>1</sup> Cost estimates refer only to the under-65 population.  
<sup>2</sup> Positive values denote increases in revenue; negative values denote decreases in revenue.  
<sup>3</sup> Positive values denote increases in spending; negative values denote decreases in spending.  
<sup>4</sup> Positive values denote surplus; negative values denote deficit.  
<sup>5</sup> This estimate does not include changes in spending on Medicaid enrollees over 65, which may be significant.



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## What About Medicare & Entitlement Reform?

## Introducing MARCOLA



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## MARCOLA >65 Evolution



- 1) 2010: First proposed idea of using the MCBS population for ARCOLA >65 at early AAF / H & E conception
- 2) 2011: Initial Model built with very limited plan choices and 'premium model' design for AHIP project work.
- 3) 2012: Get Medicare Supplement into model.
- 4) 2013: Initial model with Medicare Supplement – but lacking Premium support plan bids
- 5) 2014: Adapt prior Medicare Choice models using most recent CBS data
- 6) 2015-6: Conditional Logit and Nest Logit models with:
  - Medicare Advantage Bid Algorithm
  - Medicare Supplemental Premiums
  - Part D Premiums
  - SAS Code to permit H & E rapid extensions

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## Data Used for MARCOLA



- Analysis of Medicare health plan choices at the beneficiary/county level
- Three sources of data:
  - Beneficiary characteristics – Medicare Current Beneficiary Survey
  - MA plan benefits – Medicare Compare
  - Medigap premiums – County-specific premiums for Medigap “Plan F” from a large Medigap insurer

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## Data Exclusions



- **Sample Exclusions:**
  - Under age 65
  - Facility dwelling
  - Working
  - Medicaid
  - Employer sponsored supplemental insurance plan
  - Enrolled in a MA only plan (because of small number – not very popular)

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## Simulation #1: What if Traditional Medicare was Priced Choice



- **Establish Status Quo World**
- **Design a Priced Traditional World (Basically Ryan 2014 Premium Support)**
  - First, we need to inflate FFS costs to year t. Then you look up a county and its FFS spending level, and use these conversion factors to estimate the MA plans' bids in that county. For example, if FFS cost is between \$699 and \$746, the median MA bid is 0.97 times the FFS cost.

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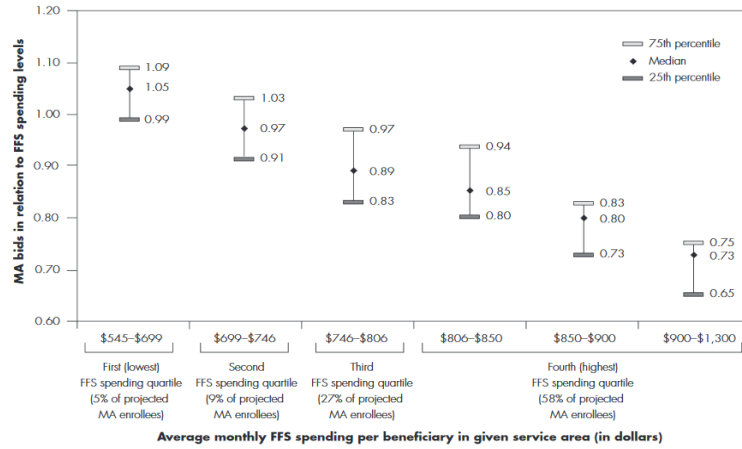
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## Plan Bid Conversions: For MEDPAC, 2015



**FIGURE 13-2**

Medicare Advantage bids in relation to FFS spending levels, 2015



## FFS vs. MA, 25<sup>th</sup> Percentile Bid, FFS wins if 0



Monthly FFS Premiums In 2016 \$\$

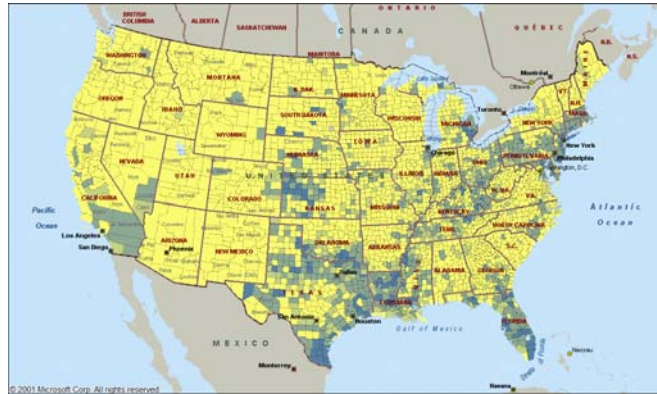
- 201 to 1,000
- 51 to 200
- 1 to 50
- 0 to 0.9

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## FFS vs. MA, 50<sup>th</sup> Percentile Bid, FFS wins if 0



Monthly  
FFS Premiums  
In 2016 \$\$

- 201 to 1,000
- 51 to 200
- 1 to 50
- 0 to 0.9

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## Big Take Away Messages



- ❑ Health Reform proposals, by either party, are not cost-neutral.
- ❑ Additional regulatory burdens (e.g., Community rating) designed to increase access will do so at high price
- ❑ Serious cost-saving reforms can be made now by those in the Administration
- ❑ The performance of both parties plans improves insurance coverage at considerable cost
- ❑ At the end, it is a political economy question of *'the will to do health reform'* - but the national debt burden has limited [2008 audacious] and [2016 HUGE!] options

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