Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers

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About The Lewin Group

The Lewin Group is a health care and human services policy research and management consulting firm. We have over 25 years of experience in estimating the impact of major health reform proposals. The Lewin Group is committed to providing independent, objective and non-partisan analyses of policy options. In keeping with our tradition of objectivity, The Lewin Group is not an advocate for or against any legislation. The Lewin Group is part of Ingenix, Inc., which is a wholly owned subsidiary of the UnitedHealth Group. To assure the independence of its work, The Lewin Group has editorial control over all of its work products.

Executive Summary

In this study we provide estimates of the cost and coverage impacts of the Patient Protection and Affordable Care Act (PPACA). We estimate the program's impact on sources of health insurance coverage and spending for the federal government, state and local governments, private employers, consumers and providers. We estimated the impact of the Act over a 10 year period from 2010 through 2019, which is consistent with the "budget window" used by the Congressional Budget Office (CBO). However, we also provide estimates for 2020 through 2029.

We developed these estimates using the Group Health Benefits Simulation Model (HBSM) developed by the Lewin Group. Our revenue and spending estimates over the 20-year period reflect the actual phase in of coverage provisions and expected lags in enrollment for newly eligible people. However, to illustrate the program's impact on sources of coverage and family spending, we present estimates assuming that Act is fully implemented and that enrollment has fully matured in 2011.

The Act

The PPACA requires most Americans to have health insurance. To assure access to affordable coverage, the Act expands the Medicaid program to cover all low-income adults living below 133 percent of the federal poverty level (FPL). The Act also provides a new premium subsidy program for people living below 400 percent of the FPL ($88,000 for a family of four).

The Act also provides a small employer health insurance tax credit for the employer's first two years of providing coverage. The credit is available to firms with fewer than 25 workers with an average employee payroll of less than $50,000. The Act also creates a temporary reinsurance program for employer sponsored retiree benefits, although the program includes only enough funding for two to three years operation.

The centerpiece of the Act is a newly established "exchange" that presents consumers with a selection of health coverage alternatives. The exchange will be available to individuals and firms with fewer than 100 workers, although the state has the option to extend the exchange to larger firms beginning in 2017. Only people participating in the exchange who do not have access to qualifying employer coverage will be eligible for the premium subsidies. The Act also reforms insurance markets by assuring guaranteed issue of coverage, limiting premium variation by age and prohibiting premium variation by health status.

The PPACA creates penalties for both employers with uncovered workers and individuals who do not have coverage.

- **Employer penalties:** Non-insuring employers with more than 50 workers pay a penalty if one or more of their workers obtain premium subsidies in the exchange. The penalty amount is equal to the lesser of $3,000 for each full-time worker receiving a premium credit, or $2,000 for each full-time worker; and
- **Individual penalties:** The Act imposes a penalty on uninsured individuals equal to the greater of $695 and 2.5 percent of income, not to exceed $2,085.

The Act is funded with reductions in spending under Medicare and additional federal tax revenues. The Act creates a new excise tax on high cost health plans (premiums over $10,200 for individuals and $27,500 for families). It also includes a second excise tax on health insurance, and new excise taxes on branded prescription drugs and device manufacturers.

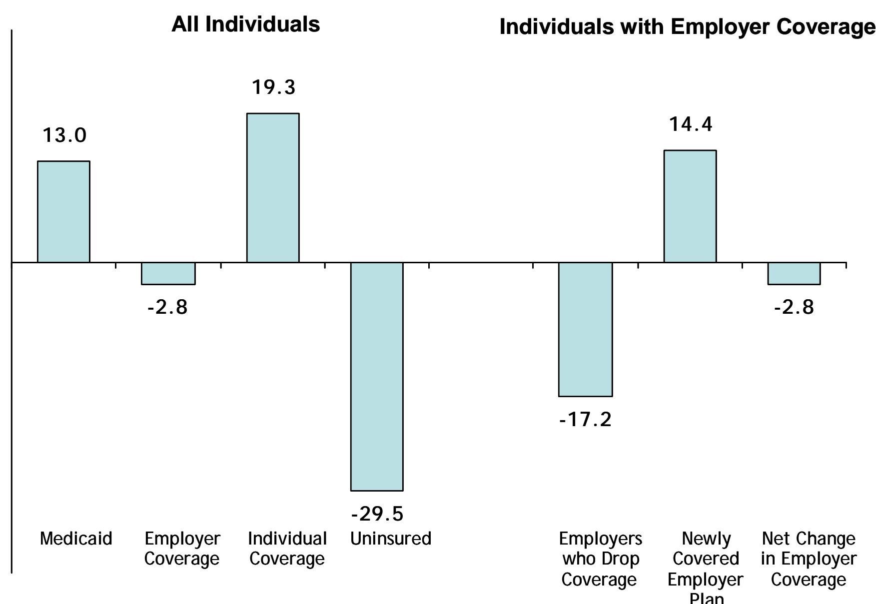
The federal government pays all of the cost of the expansion in Medicaid through 2016. A state matching requirement of 10 percent is phased-in by 2019. The Act increases the Federal Medical Assistance Percentage (FMAP) for the Children's Health Insurance Program (CHIP) by 23 percentage points, up to a maximum of 100 percent.

Coverage

The expansions in coverage are first implemented in 2014, and are not expected to reach full enrollment until after 2016. Thus, to illustrate the impact of the Act on coverage, we estimated the changes in coverage assuming the program is fully implemented in 2011 and that enrollment is fully matured in that year. We project that there will be 49.1 million uninsured in 2011 under prior law. Changes in coverage include:

- The Act would reduce the number of uninsured by 29.5 million people (***Figure ES-1***);
- Roughly half of those who remain uninsured are people exempt from the mandate such as undocumented immigrants, very low income people, and those who are exempt because they would have to pay a premium in excess of 8 percent of income;

Figure ES-1
Changes in Sources of Coverage under the Act Assuming Full Implementation in 2011 (millions) [a/]



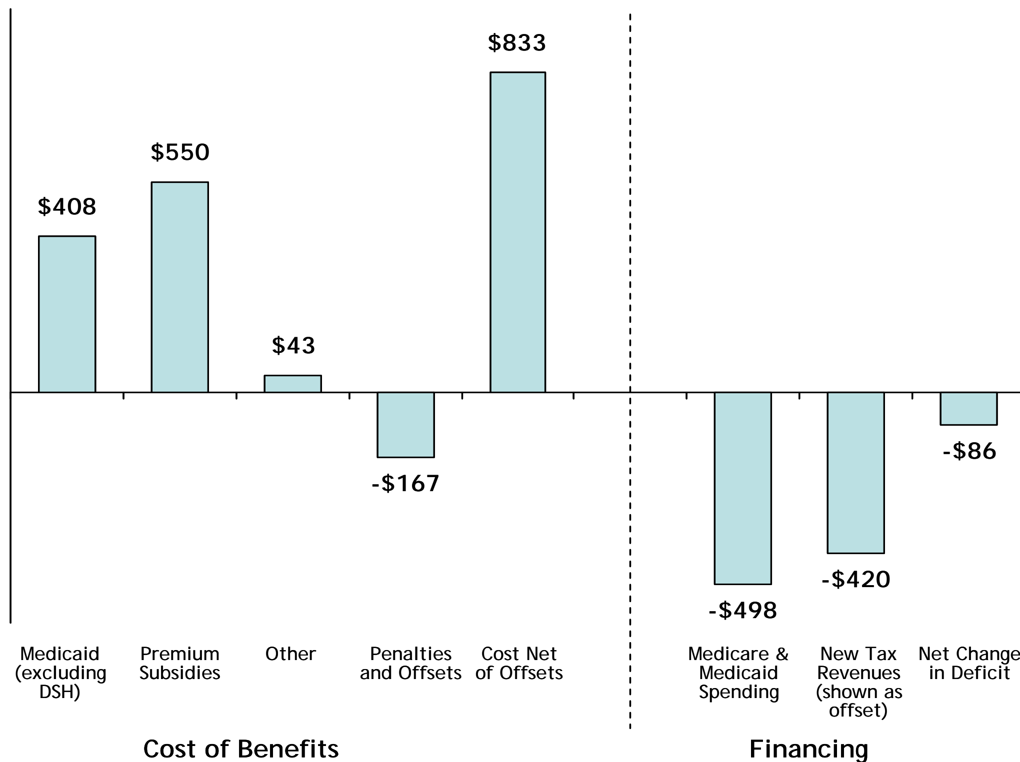
a/ For illustrative purposes, we assume that the program is fully implemented and enrollment is fully mature in 2011.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

- Medicaid and CHIP enrollment will increase by 13.0 million people;
- The number of people with employer-sponsored insurance will decline by about 2.8 million people:
  — About 17.2 million people are in firms that will drop their coverage once their workers become eligible for subsidized coverage in the exchange; and
  — About 14.4 million people are in non-insuring firms that will decide to offer coverage to avoid the penalty.
- The number of people with individually purchased private coverage will increase by 19.3 million people, which more than doubles the number of people covered under the individual market.

Federal Costs

Our analysis shows that the Act will reduce the federal deficit by $86 billion over the 2010 through 2019 period and will reduce the deficit by an additional $389 billion in the following decade (***Figure ES-2***). Revenues and expenditures for the 2010 through 2019 period include:

Figure ES-2
Federal Costs and Revenues under the Act: 2010-2019 (billions)



a/ Congressional Budget Office (CBO).
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

- Total new benefits costs will be $408 billion for the Medicaid expansion, $550 billion for the premium subsidy program and another $43 billion for the employer tax credit and other provisions of the Act;
- There will be program offsets of $167 which includes employer and individual penalty payments for people who do not have coverage and revenues from the excise tax on high cost plans;
- About half of program costs will be funded with reductions in payments to providers and health plans under the Medicare and Medicaid programs, which the CBO estimates will amount to $498 billion over the ten year period;
- The Act includes about $420 billion in new tax revenues. These include including new excise taxes on insurance, branded prescription drugs and medical devices; and
- New revenues also include an increase in the Medicare Hospital Insurance tax rate of 0.9 percentage points for people with incomes over $250,000.

State and Local Governments

We estimate that over the 2010 through 2019 period, state and local governments will save $107 billion, primarily due to savings in safety-net programs serving the uninsured. These ten-year effects include:

- State Medicaid spending will decline by about $39 billion even though states will eventually pay about 10 percent of the cost of the expansion. This is because the Act:
  - Increases the federal matching percentage for CHIP by 23 percentage points; and
  - Increases the federal matching percentage to 90 percent by 2019 for people in newly eligible groups that are already covered by the state Medicaid program (e.g., non-custodial adults).
- We estimate savings of about $100 billion for safety-net programs, such as public hospitals and free clinics, as the number of uninsured declines; and
- Health benefit costs for state and local government workers over the 2010 through 2019 period will increase by $35 billion due to the cost of penalties for uninsured workers.

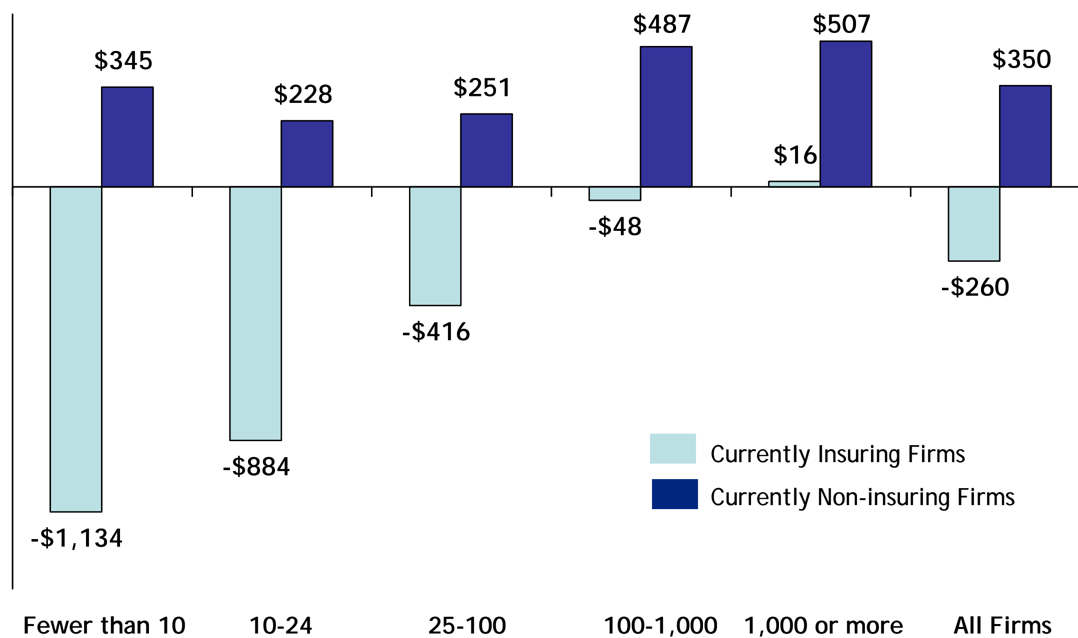
Private Employers

The Act requires all but small employers to pay a penalty for uninsured workers. As discussed above, it also establishes incentives that will cause some employers to discontinue coverage while encouraging others to begin offering insurance. The Act also provides tax credits to lower-wage firms with fewer than 25 workers for the purchase of coverage.

- Currently insuring firms will save an average of $260 per worker per year under the Act, primarily because some employers of lower-wage workers will discontinue their health plans once subsidized coverage becomes available to uninsured workers under the Act (***Figure ES-3***);

- Costs for firms that do not now offer coverage will increase by an average of about $350 per worker under the Act, reflecting the cost of either providing insurance or paying the penalty;
- Small insuring firms will save up to an average of about $1,100 per worker due to the health insurance tax credit for small employers; and
- Private employer health spending over the 2010 through 2019 period will decline by $55 billion over the 2010 through 2019 period, but will increase by $373 billion in the following decade.

Figure ES-3
Change in Private Employer Health Spending Per Worker under the Act if Fully Implemented in 2011



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.

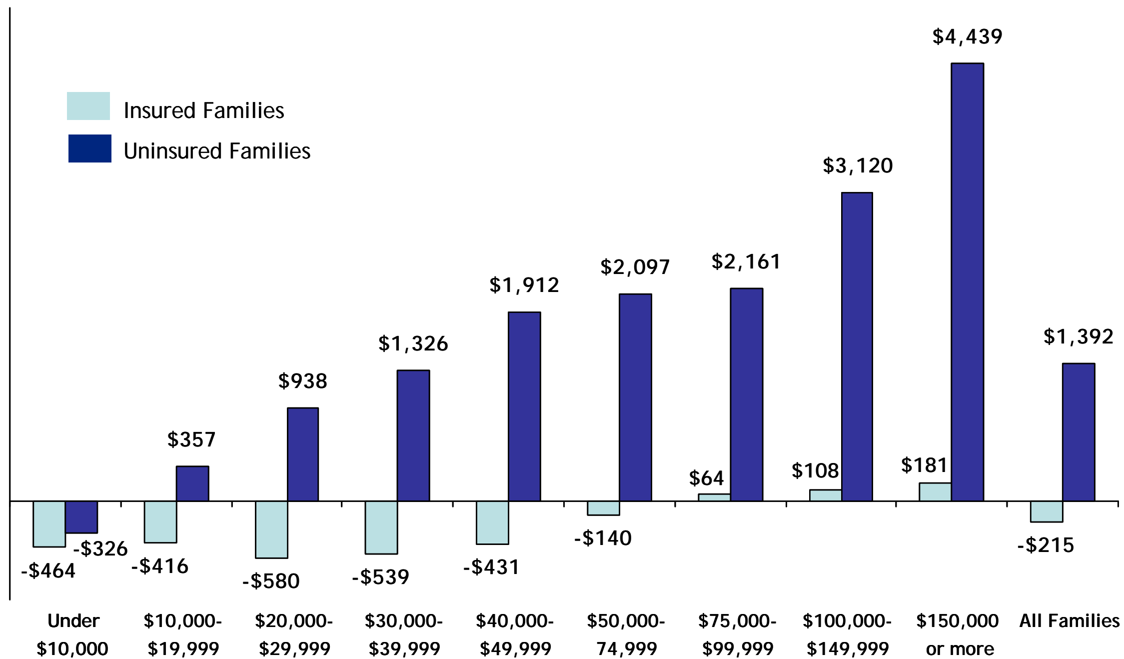
Impacts on Families

Under prior law, families would have spent an average of about $4,193 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 $1,545.

- If fully implemented in 2011, health spending will increase by about $86 per family under the Act;
- Currently insured families with income below $50,000 will see savings averaging roughly $500 per family (***Figure ES-4***); and

- Families with uninsured members will see an increase in family health spending of $1,392 per family under the Act.

Figure ES-4
Changes in Average Family Health Spending under the Act if fully implemented 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.

Impact on National Health Spending

National health spending will reach $2.77 trillion in 2011. This includes payments for all health care providers by all public and private payers and households. Health spending under the Act will increase throughout the next two decades.

- Total national health spending under the Act will increase by about $218 billion over the 2010 through 2019 period and an additional $344 billion in the following decade;
- Most of the increase in spending will be attributed to increased utilization of health services by newly insured people;
- Hospital net income will fall by about $11 billion over the 2010 through 2019 period reflecting reductions in uncompensated care and new utilization for newly insured people; and
- Physician revenues will increase by $130 billion over the 2010 through 2019 period, although these effects will vary widely across providers.

Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers

In February of 2010, the President signed into law the Patient Protection and Affordable Care Act, hereafter referred to as the "Act." The Act requires most Americans to have health insurance, and requires medium to large employers to contribute to the cost of coverage for their workers. It provides for an expansion of Medicaid, and new premium subsidy tax credits for people who can not afford to purchase coverage. It also begins the process of changing provider reimbursement systems under Medicare to pay on the basis of quality, outcomes and efficiency.

The Act has far reaching implications that will help shape the U.S. health care system for decades to come. In particular, these reforms affect spending for the federal government, state and local governments, private employers, consumers and health care providers. In this study, we present our analysis of the impact of the Act on coverage and costs for these stakeholder groups. Our analysis is presented in the following sections:

- Overview of the Act;
- Coverage effects;
- Impact on federal government spending;
- Impact on state and local government spending;
- Private employer impacts;
- Impact on consumers;
- Impact on national health spending; and
- Impact on hospital and physician income.

A. Overview of the Act

To assure access to affordable coverage, the Act expands eligibility for Medicaid to cover all adults living below 133 percent of the federal poverty level (FPL) ($29,300 for a family of four). The Act also provides subsidies for the purchase of coverage for people living between the Medicaid eligibility level and 400 percent of the FPL (i.e., $88,000 for a family of four) (***Figure 1***).

Figure 1
Summary of the Patient Protection and Affordable Care Act (PPACA) as Modified by the Reconciliation Act of 2010

Employer Penalty	Up to $2,000 per full-time worker; firms with 50 or more workers only
Dependent Coverage	Must cover dependents to age 26
Individual Mandate	Unless premiums greater than 8% income
Individual Penalty	Greater of $695 per person and 2.5% of income; amount capped at $2,085
Small Employer Tax Credit (two year limit for each firm)	Up to 50% credit for firms with fewer than 25 workers; average payroll below $50,000 per worker
Medicaid Eligibility	133% of FPL; 90% FMAP; Plus 23% CHIP
Premium & Cost Sharing Subsidies	400% FPL, 2.0%-9.5% cap as % of income
Guarantee Issue	No Lifetime Limits; creates high risk pools
Rating Restrictions	3:1 on Age; 1.5:1 on tobacco use
Medicare/Medicaid Cuts	Reduce growth in provider payments
Medicare Advantage	Changed to reduce plan "overpayments"
New Taxes	Excise tax on high-cost plans (greater than $10,200 single, $27,500 family), drugs and medical devices

In addition, the Act establishes an "exchange" that presents a selection of health coverage alternatives to individuals, the self-employed, small firms, and at the state's discretion large employers as well. Insurance markets are reformed to assure guaranteed issue and renewability of coverage to all applicants without pre-existing condition restrictions regardless of health status. Furthermore, insurers will be prohibited from charging higher premiums on the basis of health status. The key provisions of the legislation are summarized below.

1. Reforming the Insurance Markets

The Act will reform the insurance markets by creating exchanges offering a selection of health plans, and reform insurance practices to assure access to coverage for people regardless of health status.

Exchanges: The Act requires states to establish a nationwide network of health insurance exchanges. An exchange will provide consumers and participating employer groups with a

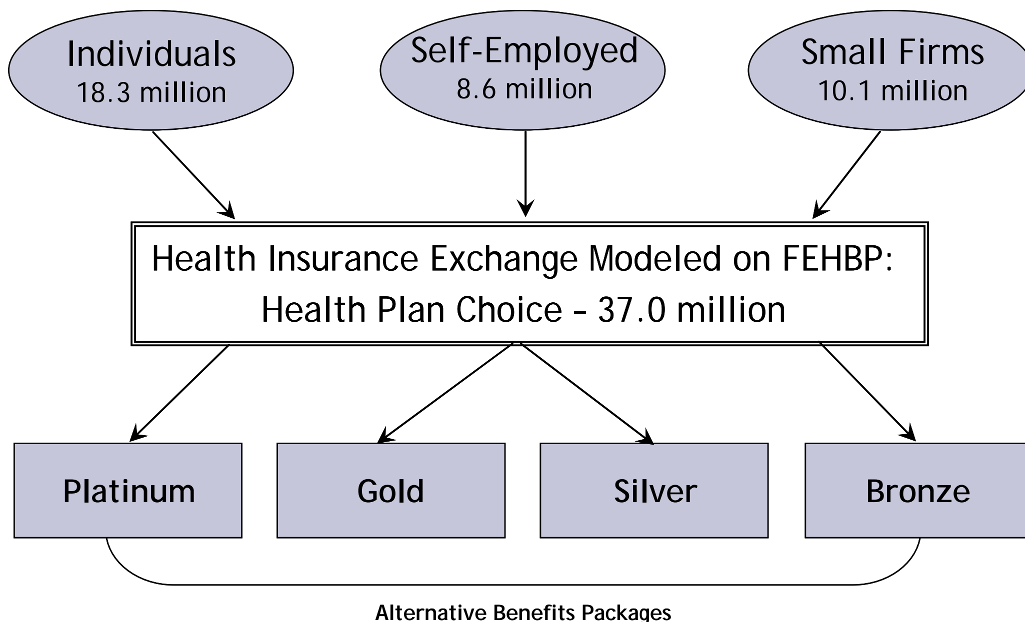
selection of health insurance plans competing on the basis of price and quality. It is designed to provide consumers with a transparent marketplace for coverage that features consumer protections and facilitates enrollment.

The Act calls for states to establish separate exchanges for individuals and small employers. However, states are permitted to combine the exchanges if they wish. The exchange for employers is initially open to firms with fewer than 100 workers. However, states have the option of extending the exchange to include larger firms at the state's discursion beginning in 2017.

The exchange will operate beside the existing insurance markets. Plans are not required to participate in the exchange. However, plans that do participate must charge the same premium for each individual insurance product in and out of the exchange.

Figure 2 presents an illustration of the exchange assuming the state elects its option to combine the individual and small employer exchanges. As discussed below, we estimate that the exchange will cover about 37.0 million people (assuming full implementation in 2011). These include 18.3 million people purchasing coverage as individuals, 8.6 million self-employed people, and 10.1 million people in small firms.

Figure 2
New State Operated Health Insurance Exchanges a/



a/ This Illustration assumes that the state has exercised its option to combine the exchanges for individuals and small groups.
Source: The Lewin Group

As discussed below, the Act requires the exchanges to offer four benefits packages ranging from a minimum plan called the Bronze plan to successively more comprehensive plans including the Silver, Gold and Platinum plans.

Immediate Changes in Insurance: The PPACA creates numerous changes in the insurance markets that will first apply from six months following passage of the Act to 2014 when the new exchanges are to begin operations. As shown in ***Figure 3***, the Act requires all plans to permit coverage of dependent children through the age of 26, and requires plans to cover preventive health services without patient cost sharing. It also prohibits "rescissions" of coverage except in cases of fraud, eliminates lifetime limits and restricts annual limits.

Figure 3
Insurance Reforms under PPACA by Type of Health Plan

Section		Type of Health Plan			
		Individual	Small Group	Large Group	Self-funded
Effective Six Months after Enactment					
2711	Eliminate Lifetime Limit	✓	✓	✓	✓
2712	Restrict Annual Limits	✓	✓	✓	✓
2712	Prohibition on Recessions	✓	✓	✓	✓
2713	No Cost sharing for Preventive Care	✓	✓	✓	✓
2714	Cover Dependents to Age 26	✓	✓	✓	✓
2715	Uniform Benefits Description	✓	✓	✓	✓
2716	Prohibit Discrimination by Salary	NA	✓	✓	
2794	Premium Rate Review	✓	✓	✓	
Provisions Taking Effect in 2014					
2704	Eliminate Preexisting Condition Exclusions	✓	✓	✓	✓
2701	Rating Rules (3:1 age: 1.5:1.0 Tobacco use)	✓	✓	If in Exchange	NA
2702	Guaranteed Issue (Subject to open Enrollment period)	✓	✓	✓	NA
2703	Guaranteed Renewal (permits use of open enrollment)	✓	✓	✓	NA
2705	Prohibit Discrimination on Health	✓	✓	✓	✓
2707	Coverage for Essential Benefits	✓	✓		
2708	Maximum Deductible ($2,000 individual; 4,000 family)		✓		
2707	90 day Maximum Waiting Period	✓	✓	✓	✓

Source: The Lewin Group

Also, states are required to implement a health insurance premium rate review process, which includes enforcement of new limits on the minimum share of premium revenues that must be devoted to patient care expenses, known as the minimum loss ratio (MLR). The MLR will be 80 percent in the individual and small group markets and 85 percent in the large group market.

In addition, the Act creates a temporary high-risk pool for people with pre-existing conditions which we discuss below in greater detail.

Medical Underwriting and Rating Practices: Beginning in 2014, the Act prohibits the practice of "medical underwriting," a process whereby insurers can deny coverage or charge higher premiums on the basis of health status. The Act requires insurers to guarantee issue and renewal of coverage to all applicants without imposing pre-existing health condition exclusions. It also prohibits insurers from charging more for people with a history of illness. In addition, the Act imposes a maximum waiting period of 90 days.

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 3:1. Insurers may also vary premiums with tobacco use by a factor of 1.5:1. As discussed below, the Act also provides for a temporary high risk pool program for people with pre-existing conditions who have been uninsured for six months which will be available until the exchange is open and the insurance market reforms are fully implemented (***Exhibit 1***).

Risk Pooling in the Insurance Markets: The Act requires all plans selling individual or small group coverage to participate in a risk adjustment system that applies to all insurance sold in these markets including those covered in and out of the exchange. The risk adjustment system collects funds from plans that have a disproportionately low risk population and transfers these funds to plans accumulating a disproportionately costly population.

The Act also creates a temporary reinsurance program for plans that accumulate higher than average cost people in the individual market. The program lasts from 2014 through 2016, after which the population is assumed to have "aged" into the insured population with more predictable costs.

Benefits Packages: The Act specifies a minimum "essential" benefits package for coverage sold in the individual and small group insurance markets. The Act specifies a list of services that must be covered. The Secretary will be required to review and update these lists of covered services on a regular basis. The minimum services specified in the Act 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;

Exhibit 1
Temporary High Risk Pool

The Act creates a high risk pool program in each state to expand access for people with pre-existing conditions, until the exchanges are opened in 2014. States have the option of either setting them up themselves or allowing the federal government to create the high risk pool for the state. Approximately 28 states have elected to establish their own pools.

The high risk pool is available to people with pre-existing conditions that have been uninsured for at least six months. This means that people who have lost coverage or are about to exhaust their COBRA benefits will need to go bare for six months before they can enroll. Individuals also must be a citizen or lawful resident to participate.

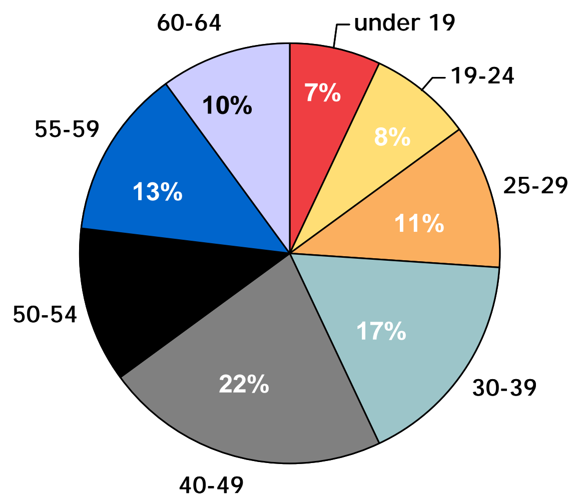
Individuals will pay a premium equal to 100 percent of "standards risk," which is an estimate of the average cost of the benefits across individuals of comparable age. This differs from most existing state high-risk pools which typically require a premium equal to 150 percent or more of standard risk. The Act limits premium variation to a 4:1 ratio, meaning that the premium for the highest age group must be no greater than four times the premium for the least costly age group.

The Act provides $5.0 billion in funding for losses under the risk pool over the 2010 through 2013 period. Losses are equal to total costs for participants in excess of beneficiary premium payments. The pool does not provide additional premium subsidies for low income people and no additional funding is provided for existing state high risk pools.

The Medical Expenditures Panel Survey (MEPS) data show that there are about 9.9 million uninsured people who have one or more of the pre-existing conditions that typically result in denial of coverage or a "rating-up" of premiums in existing markets where permitted. This is based upon the list of conditions that are currently used to determine eligibility for the existing high risk pools in Colorado, Tennessee and Texas.

We estimate that about 396,000 people would enroll in the program. Losses in the first full year of operation would be about $1.96 billion nationally. At this rate, the $5.0 billion allocated for the program would be exhausted in early 2013.

Uninsured with Pre-existing Condition by Age



Number of People - 9.9 million
Enrolling - 396,000
Losses first year - $1.96 billion

- 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 denominates coverage in the form of an actuarial value. Under this scale, a plan that covers all of these services listed above will have an "actuarial value" of 1.0. The actuarial value of the plan falls as the amount of patient cost sharing (i.e., co-payments and deductibles) increases. These plans must provide preventive care services with no cost sharing (except in cases where value-based benefits design is used).

The Act specifies that the minimum benefits package will have an actuarial value of 0.6. This means that on average, the policy is expected to cover 60 percent of an individual's health expenses while the individual will on average pay 40 percent. However, the plan may vary the cost sharing amounts, subject to certain limitations. These include:

- The plan must cover preventive services without cost sharing, with exceptions for plans with value based cost sharing;
- There can be no lifetime or annual limits on benefits;
- There is a maximum out-of-pocket limit of $5,950 for individuals and $11,900 for families (These are the maximum cost-sharing amounts for Health Savings Accounts under current law); and
- Once the out-of-pocket cap is met, the plan pays for all covered costs without annual or lifetime limits on benefits.

To illustrate their likely coverage characteristics, we estimated example combinations of deductibles and co-payment amounts for covered services that will correspond to the actuarial values of the minimum benefits package under the Act (***Figure 4)***. One package that will meet the 0.6 percent actuarial value standard will include a deductible of $2,500 per person and 40 percent co-payments for other services. Thus, the package is essentially a catastrophic policy with large co-payments up front and full coverage after the out-of-pocket maximum ($5,950 single; $11,900 family) is met.

Figure 4
Illustrative Cost-Sharing Amounts Consistent with Actuarial Valuation of the Basic Benefits Options [a/]

	Minimum Benefits Packages	
	Without Cost Sharing	Acts Bronze Package
Actuarial Value	1.0	0.60
Hospital Deductible	$0	$2,500
Hospital Coinsurance	0%	40%
Deductible – Single	$0	$2,500
Deductible – Family	$0	$5,000
Medical Services Coinsurance	0%	40%
Prescription Drugs Coinsurance	0%	40%
Preventive Care Coinsurance	0%	0%
Copayment limit – Single	$0	$5,950
Copayment – Family	$0	$11,900
PMPM in 2011 [/b]	$424	$254

Parameters specified in legislation

a/ Estimates developed using Medical Expenditure Panel Survey (MEPS) data for people currently covered under employer plans. We assumed that the intent of the Act 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 will be somewhat lower if the utilization response is incorporated into the estimates.
b/ Benefits costs only. Estimates do not include insurer administration.
Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM).

As discussed above, insures may sell a range of coverage options in the exchange. These policies must cover the same list of services and the minimum benefits package, known as the bronze plan. However, they can also offer plans with lower cost sharing amounts at actuarial values of 0.7 for the silver plan, 0.8 for the gold package and 0.9 for the platinum package. By comparison, we have estimated that the Blue-Cross Blue Shield standard option offered to federal workers has an actuarial value of 0.88. Example cost sharing amounts corresponding to these actuarial values are presented in ***Figure 5***.

Figure 5
Example Co-payments Meeting Actuarial Standards under PPACA: Illustrative Estimates for 2011

	Actual Value	Example Deductible	Example Coinsurance
Benefits Packages in the Exchange			
Platinum Package	.90	$100/$200	10%
Gold Package	.80	$600/$1,200	15%
Silver Package	.70	$1,200/$2,400	25%
Bronze Package	.80	$2,500/$5,000	40%
Bronze Small Employer	.60	$2,000/$4,000	50%
Cost Sharing Subsidy Health Plans			
Less than 150% FPL	.94	$0/$0	8%
150% to 200% FPL	.87	$150/$300	10%
200% to 250% FPL	.73	$1,000/$2,000	25%
250% to 400% FPL	.70	$1,200/$2,400	25%

Parameters specified in legislation

a/ The Act also reduces the maximum out-of-of pocket spending limits by income level.
Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM).

2. Individual Responsibility

The Act requires most people 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 equal to the greater of $695 per uninsured individual or 2.5 percent of income up to a maximum for $2,085 for families. The penalty will be phased-in by 2016 as follows:

- 2014: $95 up to 1.0 percent of income;
- 2015: $325 up to 2.0 percent of Income; and
- 2016 and after: $695 up to 2.5 percent of income.

These penalty amounts will be indexed annually to the Consumer Price Index beginning in 2017.

The penalty does not apply to undocumented immigrants, people living below the tax filing threshold and individuals who have been uninsured for three months or less. People are also exempt from the penalty if the lowest cost option available to them exceeds 8 percent of income. Available coverage includes individual coverage and employer coverage if offered.

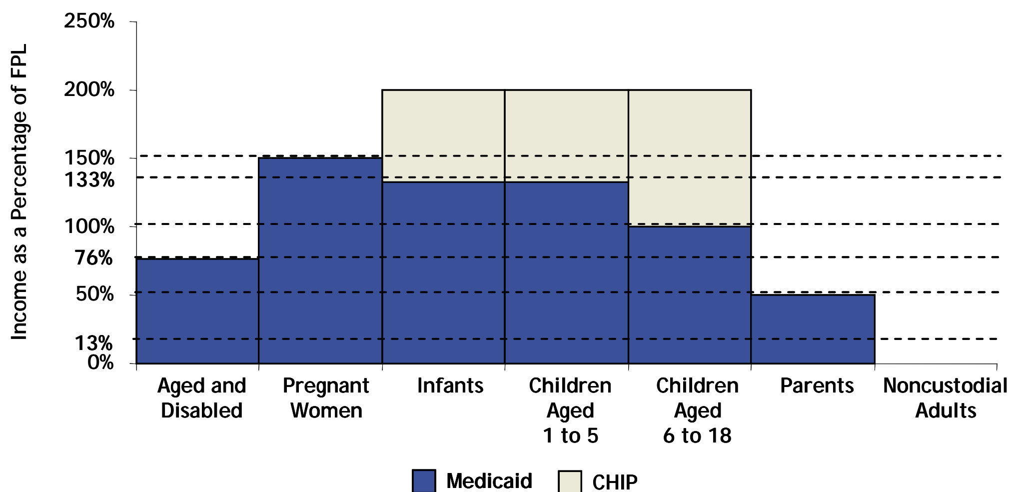
3. *Expanding the Role of Medicaid*

The Act expands eligibility for Medicaid to cover many poor adults who are not currently eligible for the program.

Program Eligibility: Eligibility for the existing Medicaid and the Children's Health Insurance Program (CHIP) 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 raise the eligibility level to 300 percent or more of the FPL. Pregnant women are typically eligible through 150 percent of the FPL.

Custodial parents are typically eligible for Medicaid if their income is below an average of about 50 percent of the FPL, although this varies by state. For example, the income eligibility level for parents varies from 17 percent of the FPL in Arkansas and 215 percent of the FPL in Minnesota. 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 6***).

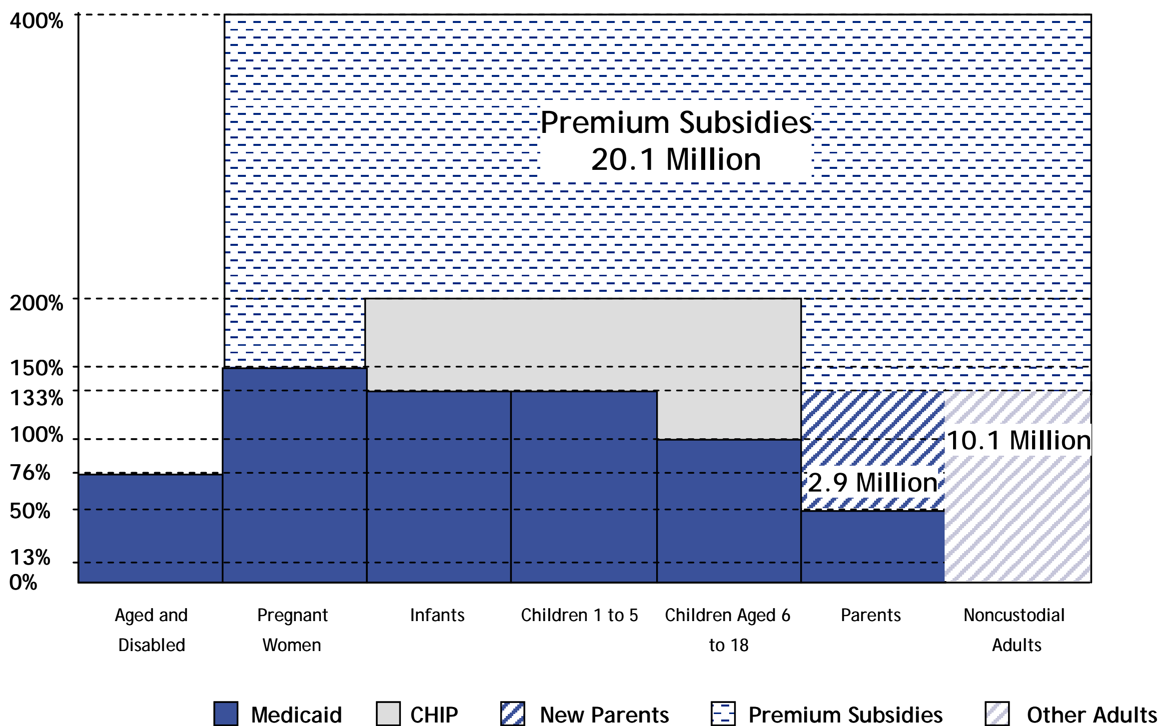
Figure 6
Medicaid and CHIP Eligibility for a "Typical State" Under Current Law [a/]



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.

The Act requires states to cover all adults under age 65 through 133 percent of the FPL, including parents with children and non-disabled individuals without custodial responsibilities for children beginning in 2014 (***Figure 7***). States are required to maintain existing income eligibility levels until the exchanges are established. The CHIP program is retained in its current form.

Figure 7
Expansions in Publicly Subsidized Coverage under the Act



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

The Act eliminates the use of income disregards for determining eligibility, and will base income eligibility on modified gross income.[1] 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. We estimate that the program will cover an additional 2.9 million parents and 10.1 million non-custodial adults (***Figure 7***).

Newly eligible adults are guaranteed a benchmark benefits package that covers at least the "essential" benefits described above. However, the Act does not specify cost sharing levels.

Federal Matching Funds: The federal government currently matches state spending for Medicaid and CHIP 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.

The existing FMAP for Medicaid will remain at its current levels for most currently eligible groups. The federal government will pay 100 percent of costs for newly eligible groups through

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

2016. Matching rates will phase down to 90 percent for newly eligible people in 2019 and thereafter.

In states that already cover the groups made newly eligible under the Act, the federal matching rates for these people will be phased up starting in 2014 at their current levels to 90 percent by 2019 and thereafter. The Act also increases the CHIP enhanced FMAP for states by 23 points, not to exceed a total matching rate of 100 percent.

4. Premium and Cost Sharing Subsidy Program

The Act also creates a new tax credit to assist individuals and families in purchasing private health insurance coverage. The program is designed to assist those with incomes that are too high to qualify for Medicaid, but too low to afford the full cost of private insurance. The Act provides subsidies through 400 percent of the FPL, which is equal to about $88,000 for a family of four. In addition, the Act provides subsidies to cover co-payments for people eligible for the premium subsidies (i.e., below 400 percent of the FPL).

We estimate that if fully implemented in 2011, about 20.1 million people will be receiving premium and cost-sharing subsidies.

Premium Subsidies: The Act provides a refundable premium tax credit for the purchase of coverage through the state exchanges. The credits will be based on the cost of the premium as a percentage of income. The credit will limit family premium payments as a percentage of income, ranging from 2.0 percent of income for eligible people living below 133 percent of the FPL to 9.5 percent of income for those between 300 percent and 400 percent of the FPL. These subsidy thresholds include:

- Up to 133 percent of FPL: 2 percent of income;
- 133 percent to 150 percent of the FPL: 3 percent to 4 percent of income;
- 150 percent to 200 percent of the FPL: 4 percent to 6.3 percent of income;
- 200 percent to 250 percent of the FPL: 6.3 percent to 8.05 percent of income;
- 250 percent to 300 percent of the FPL: 8.05 percent to 9.5 percent of income; and
- 300 percent to 400 percent of the FPL: 9.5 percent of income.

A cap of 2.0 percent applies to people between the FPL and 133 percent of the FPL who have the option of taking coverage in the exchange rather than Medicaid.

Between 2014 and 2018, these percentage limits are indexed according to growth in premiums for the prior year over the average rate of growth in income over the year. Beginning in 2019, these percentages will be indexed by an additional factor equal to the rate of premium growth over the growth in the consumer price index for the preceding year.[2]

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[2] This second adjustment will apply only if the aggregate amount of premium tax credits and cost-sharing subsidies exceeds an amount equal to 0.504 percent of gross domestic product (GDP).

Cost-sharing Subsidies: The Act also subsidizes co-payment amounts for people receiving premium subsidies. This is done by buying eligible people into a plan with reduced levels of co-payments. Plans are paid an additional premium to cover the cost of this supplemental coverage. The Act sets the actuarial value of coverage by income as follows:

- 100 percent to 150 percent of the FPL: 94 percent;
- 150 percent to 200 percent of the FPL: 85 percent;
- 200 percent to 250 percent of the FPL: 73 percent; and
- 250 percent to 400 percent of the FPL: 70 percent.

The Act also specifies maximum out-of-pocket spending limits for people living below %400 percent of the FPL. These include:

- 100 percent to 200 percent of the FPL: $1,983 individual and $3,967 per family;
- 200 percent to 300 percent of the FPL: $2,975 individual and $5,950 per family; and
- 300 percent to 400 percent of the FPL: $3,987 individual and $7,973 per family.

Example cost sharing amounts that are consistent with these actuarial values are included above in ***Figure 4***.

Eligibility for Subsidies: These premium and cost sharing subsidies are available only to those participating in the exchange as individuals. People who are offered employer coverage are not eligible for subsidies, except in certain cases. Workers offered a plan that does not meet the minimum benefits criteria and workers who find that the premium exceeds 8.0 percent of income may enroll in the exchange and qualify for subsidies. Undocumented immigrants are excluded from the exchange and do not qualify for subsidies.

5. Employer Responsibility

Employers are not required to cover their workers. However, beginning in 2014, firms with 50 or more workers must pay a penalty if any of their full-time workers receive subsidies for coverage through the exchange. The Act also provides a tax credit to small employers for up to half of their cost of health insurance as an inducement for small firms to offer coverage.

Employer Requirements and Penalty Payments: Firms with 50 or more workers that do not offer coverage will be required to pay a penalty if one or more of their full-time workers obtain a premium credit through the exchange. The penalty will be equal to the lesser of, $3,000 for each employee receiving a credit, or $2,000 for each full-time worker, excluding the first 30 full-time workers. These fees are paid monthly based upon 1/12th of the specified fee amounts.

Employers who offer insurance are required to provide a "free choice voucher" to employees with incomes below 400 percent of the FPL. The voucher would be applied to the cost of coverage for these individuals in the exchange. This applies only to workers whose premium share under the employer's plan would exceed 8 percent of family income, but not greater than 9.8 percent of family income. The Act also requires insuring employers with 200 or more

employees to automatically enroll all eligible employees. However, employees would have the option to decline that coverage.

Small Employer Tax Credit: The Act provides employers with fewer than 25 workers a tax credit for the purchase of insurance for their workers. The tax credit is potentially equal to 35 percent of employer contributions for qualified coverage beginning in 2010, increasing to 50 percent of the premium in 2014 and thereafter. For tax-exempt employers, the credit is available for up to 25 percent of premiums prior to 2014, and 35 percent of premiums beginning in 2014.

To qualify, the employer must pay at least 50 percent of the premium. The amount of the credit is phased-out for firms with average annual earnings per worker between $25,000 and $50,000. The amount of the credit is also phased-out for employers with between 10 and 25 employees. The credits are available for the first two years that an employer offers qualified coverage only, and terminate at the end of the second year.

Retiree Reinsurance: The Act provides funding for a reinsurance program that will assist employers sponsoring retiree benefits plans. The program will cover expenses in eligible firms for individual retirees with high expenditures. The program will cover 80 percent of costs between $15,000 and $90,000. The health plan would continue to cover costs not paid by the reinsurance, including costs in excess of $90,000. The Act provides $5.0 billion in funding for the program, which is likely to be exhausted in three years.

6. *Financing Measures*

The Act will be funded with savings gained from 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 will result in net savings over the 2010 through 2019 period of $498.1 billion.

Much of these savings will be attributed to reductions in the rates of growth in provider payments for services. The Act also revises the competitive bidding process for Medicare Advantage that will result in substantial savings to Medicare. The Act does not change the "sustainable growth rate" (SGR) formula for Medicare payments to physicians and other health practitioners.[3] The Act will also reduce Disproportionate Share Hospital (DSH) payments under the Medicare and Medicaid programs to reflect the expansions in coverage under the Act.[4]

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[3] Payments to physicians under Medicare are computed with the "sustainable growth rate" formula. Under current law, payments to physicians will be reduced by about 21 percent, due to increases in the volume of services provided, which is a factor in updating payments for individual services.

[4] The Medicare and Medicaid programs each provide hospitals with roughly $10 billion in supplemental payment for hospitals serving a disproportionate share of Medicaid patients and uninsured people. The payments are reduced under the Act to reflect the reduction in the number of people with insurance.

Excise Taxes: The Act creates new excise taxes on private health insurance, prescription drugs and durable medical equipment.

The largest of these will 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 $10,200 for individuals and $27,500 for families beginning in 2018. The threshold is increased by $1,650 for individuals and $3,450 for families with workers in high risk occupations and retirees age 55 through 64.

These thresholds are indexed each year by the CPI. However, the Office of the Actuary of the Centers for Medicare and Medicaid services estimates that health spending will grow at over twice that rate. Because of this growth, the number of health plans affected and the amounts subject to the tax will increase over time. We present estimates of the number of people affected in our discussion of federal costs below. We estimate that this will raise revenues of about $36.7 billion over the 2018 through 2019 period, and $844.2 billion over the 2020 through 2029 period.

The Act imposes an additional excise tax on insurance (excluding self-funded coverage) increasing from $8.0 billion in 2014 to $14.3 billion by 2019. It also imposes excise taxes on brand name drugs and medical devices. The full amount of these taxes is expected to be passed on to consumers in the form of higher health insurance premiums.

Other sources of Financing: The Act includes several other sources of financing. The largest of which is an increase in the Medicare Hospital Insurance payroll tax by 0.9 percent for people with incomes over $250,000. These revenue measures include:

- Health Deductions and Exclusions
  - Increase Penalty for non-qualified HSA distributions
  - Limit Flexible Spend amount to $2,500
  - Conform medical expense definition for FSAs, MSAs and deduction
  - Raise health spending deduction threshold to 10 percent of Adjusted Gross Income (AGI)
- Fee for Comparative Effectiveness
- Added 0.9% hospital insurance tax over $250,000
- Require health needs assessment for 501(c)(3) hospitals
- Eliminate 833 deductions if minimum loss ratio (MLR) less than 85 percent
- Eliminate deduction for expenses related to Part D subsidy
- Other provisions

B. Coverage Effects

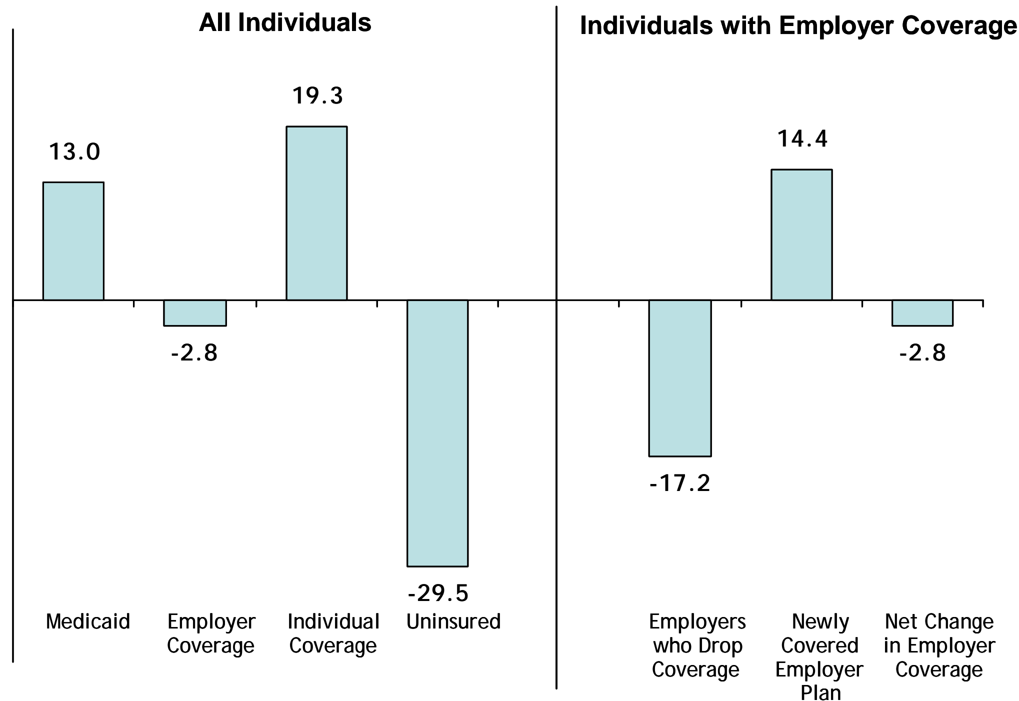
The Act will result in significant shifts in coverage for millions of Americans including those covered by both public and private coverage. In this section we illustrate the changes in coverage resulting from the coverage provisions of the Act and new incentives created in the law.

1. Changes in Sources of Coverage

We project that there will be about 49.1 million uninsured people in 2011 under prior law. We estimate that 29.5 million of these people will become insured under the Act (***Figure 8***). The Medicaid program will see a net increase in enrollment of 13.0 million people. The number of people with employer coverage will be reduced by 2.8 million, which we discuss further below.

The number of people with coverage in the individual market will increase by 19.3 million, which will more than double the number of people covered in the individual market. People eligible for Medicare or TRICARE (i.e., coverage for military dependents and retirees) will not be eligible for subsidies under the Act and will remain covered by these sources.

Figure 8
Changes in Sources of Coverage under the Act Assuming Full Implementation in 2011 (millions)



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

2. Changes in Employer Coverage

We estimate that the number of people with private employer-sponsored insurance (ESI) will decline by about 2.8 million. This includes people with private ESI and those covered by their employer through the exchange. Thus, people with employers who cover their workers through the exchange are counted as having ESI.

However, this small loss of coverage masks extensive shifts to and from employer plans. About 17.2 million workers and dependents that will lose their ESI, primarily in firms where the employer decides to discontinue their health plan once the expanded Medicaid and premium subsidy programs become available (***Figure 9***). Because premium subsidies are not available to people who are offered ESI, many employers will find that it is less costly for the workers to obtain their coverage through Medicaid or the new premium subsidy program than it is to continue employer plans.

These discontinuations of employer coverage are known as “crowd-out.” This will affect many employers since subsidies are available through 400 percent of the FPL, which is about $88,000 for a family of four.

However, this loss of employer coverage is partly offset by increased employer coverage of 14.4 million people. This will occur among firms that decide to start offering coverage to avoid the new employer penalty payments. Some of these firms will start to offer coverage because their insurance premiums will be reduced due to the elimination of health status rating or the new small employer tax credit.

In ***Figure 9***, we present a detailed accounting of how sources of coverage will change for people by their insured status under prior law. For example, of the 154.4 million workers and dependents that now have ESI, only about 130.5 million will remain with their current health plans. About 6.8 million will be in insuring firms that will shift their workers to the small group exchange.

About 17.2 million people will lose ESI. Of these, 8.6 million will receive premium subsidies in the exchange, 3.7 will enroll in Medicaid, 3.9 million will be covered in the exchange without subsidies and about 1.0 million will go uninsured. ***Figure 9*** shows transitions in coverage for other groups as well.

Figure 9
Change in Sources of Coverage under the PPACA Assuming Full Implementation in 2011
(millions)

		Private Coverage Through Exchange			Private Coverage Out of Exchange		Medicaid & CHIP (excl duals)	Medicare, TRICARE & Other	Uninsured
		Employer	Individual		Employer	Individual			
			With Subsidy	Without Subsidy					
Employer Workers and Dependents	**154.4**	6.8	8.6	3.9	130.5	0	3.7	0	1.0
Non-Group	**14.3**	0.4	3.5	0.6	2.1	6.7	0.7	0	0.2
Employer Retiree	**3.7**	0	0	0	3.7	0	0	0	0
TRICARE	**6.1**	0	0	0	0	0	0	6.1	0
Medicare	**33.2**	0	0	0	0	0	0	33.2	0
Medicare Dual Eligible	**6.8**	0	0	0	0	0	0	6.8	0
Medicaid/CHIP	**41.7**	0.6	0.4	0.1	1.4	0	39.2	0	0
Uninsured	**49.2**	2.4	7.6	2.2	7.6	0	11.0	0	18.5
Total	309.5	**10.1**	**20.1**	**6.8**	**145.3**	**6.7**	**54.9**	**46.2**	**19.7**

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

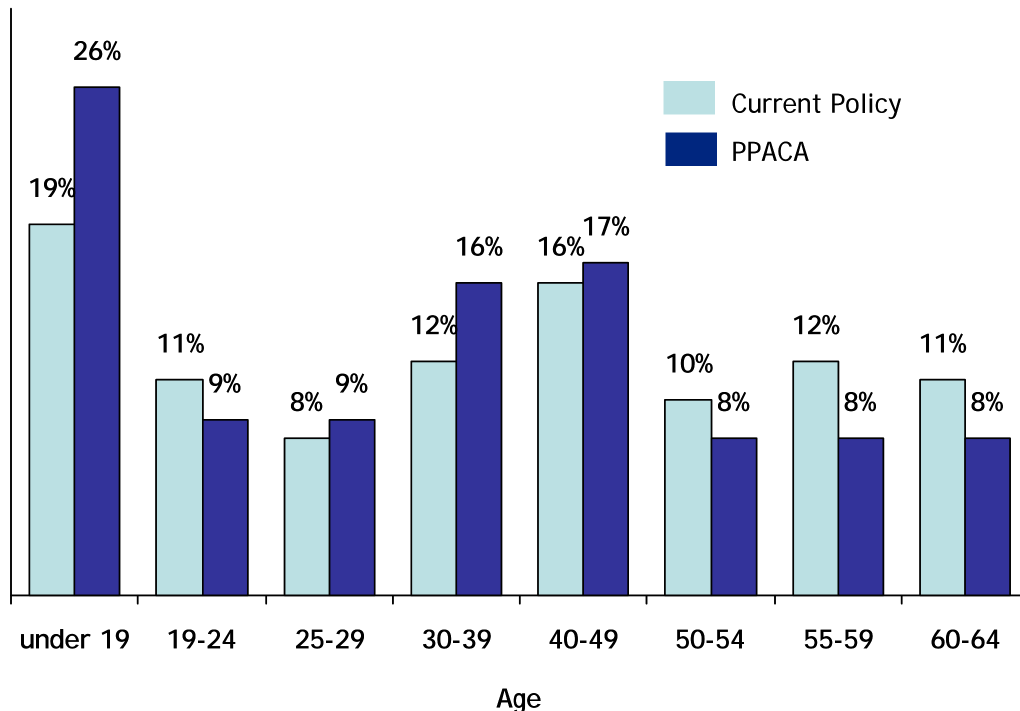
3. Individual Coverage

As discussed above, we estimate that the number of people with individual coverage will increase by 19.3 million. This will increase the number of people participating in the individual market from 14.3 million under prior law to 31.0 million under the Act.

This is crucial to implementing guaranteed issue in the individual market. This increase in the market provides a broad base for spreading risk. This means that plans can eliminate pre-existing condition exclusions while enrolling both healthy and sicker people currently excluded from coverage. This broadened risk pool for individual coverage is necessary to eliminate medical underwriting in the individual market without causing large increases in premiums which is what happened in New York and Massachusetts when these states required guaranteed issue of coverage.

Figure 10 compares the age distribution of people with non-group coverage under the Act with those with individual coverage under prior law. The new age distribution is shifted more to the lower age groups which should help stabilize premiums in the non-group market.

Figure 10
Distribution of People with Non-Group Insurance under Prior Law and under PPACA by Age

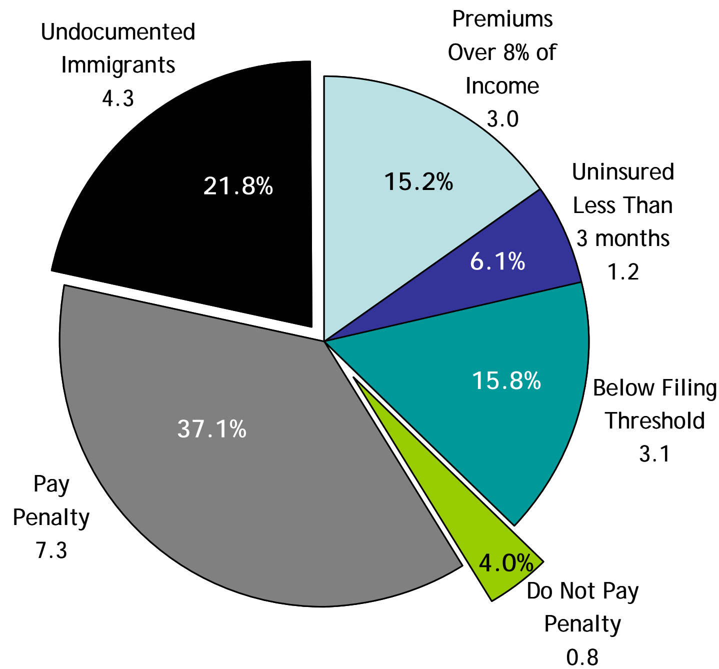


Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM).

4. *People who Remain Uninsured*

As discussed above, some of the uninsured will not become covered. About 19.7 million people will remain uninsured (***Figure 11***). Over half of those who remain uninsured will be exempt from the mandate.

Figure 11
People Who Remain Uninsured under the Act (millions) [a/]



Total Remaining Uninsured = 19.7

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

About 4.3 million undocumented immigrants will be exempt from the mandate and ineligible for Medicaid and the premium subsidy program. About 3.0 million of those remaining uninsured will be those exempt from the penalty because premiums will exceed 8 percent of income. Another 3.1 million are those specifically exempted from the mandate because their incomes are less than the tax filing threshold. About 8.1 million people will elect to pay the penalty rather than obtain coverage. (About 7.3 million of which will actually pay the penalty).

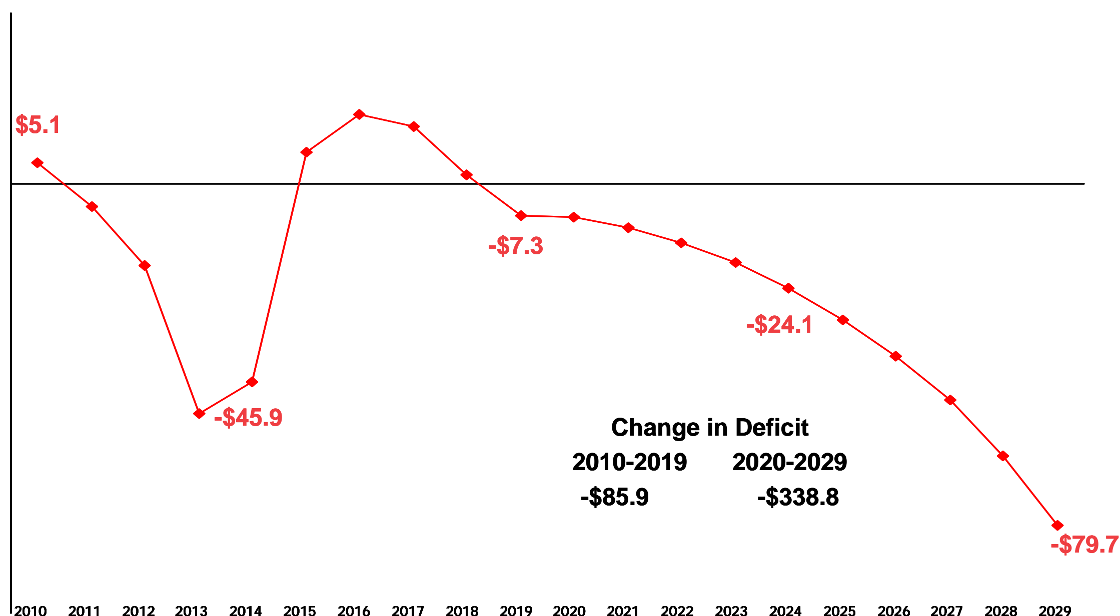
C. Impact on Federal Spending

We estimate 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 at the point of enactment, was 2010 through 2019. Because the coverage expansions under the Act will not take effect until 2014, the program will be in operation for only 6 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.

1. *Impact on Federal Deficit*

We estimate that the Act will reduce the federal deficit by $85.9 billion over the 2010 through 2019 period ***(Figure 12***). During the 2020 through 2029 period, the Act will reduce the deficit by another $338.8 billion.

Figure 12
Change in Federal Deficit under the Act: Without SGR Correction (billions)



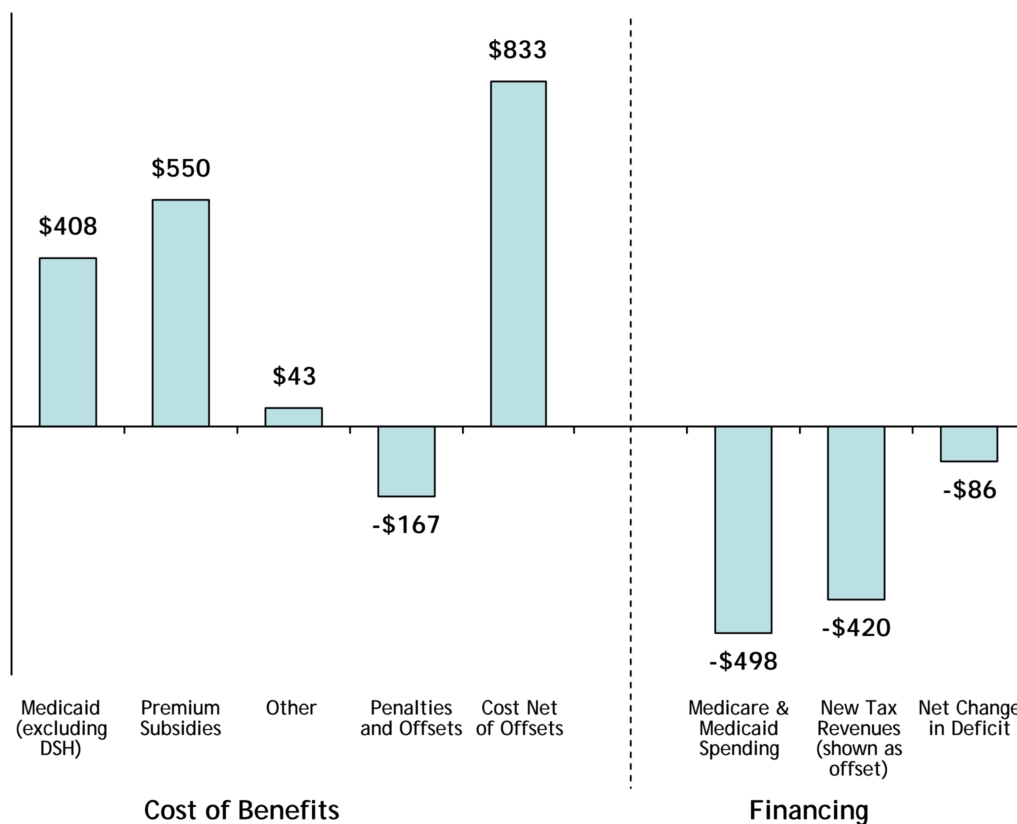
Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM)

Total new federal spending for benefits over the 2010 through 2019 period will be $1.0 trillion. These include Medicaid spending of $408 billion, premium/cost-sharing subsidies of $550 billion and small employer tax credits and other spending of $43 billion. These new costs will be partly offset by other effects including individual and employer penalties, revenues, revenues from the excise tax on high cost plans and changes in federal tax revenues resulting from changes in employer health spending. The total cost of the program after subtracting these offsets ($167 billion) will be $833 billion.

As shown in ***Figure 12***, we project that the amount of the reduction in the federal deficit will increase at an increasing rate after 2020. This is partly because the Act slows the annual rate of growth in provider payments under Medicare, which slows the rate of growth in federal health spending over time (i.e., savings compound over time). It also reflects that the tax on high cost health plans will affect more and more people each year because insurance premiums will continue to grow faster than income (discussed below).

These new costs are partly financed by reductions in spending under the Medicare and Medicaid programs of $498 billion. The Act will also raise about $420 billion in new tax revenues including the new excise taxes on health plans and other excise taxes on branded prescription drugs, medical devices and a second excise tax on health insurance. This results in a net reduction in the federal deficit of about $85.9 billion over the 2010 through 2020 period (***Figure 13***).

Figure 13
Federal Costs and Revenues under the Act: 2010-2019 (billions)



a/ Medicare and Medicaid spending and tax revenue estimates are based upon estimates prepared by the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT).
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 14 provides a detailed accounting of costs and revenues under the Act from 2010 through 2029.

Figure 14
Changes in Federal Expenditures and Revenues under the Act: 2010-2029
(billions)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Public Program Costs											
Medicaid Eligibility Expansion	-$0.1	-$0.2	-$0.3	-$0.3	$24.4	$57.6	$74.6	$77.7	$83.8	$90.3	$407.6
Premium Subsidies	$0.0	$0.0	$0.0	$0.0	$34.9	$75.2	$91.8	$105.7	$115.7	$126.3	$549.6
Employer Tax Credit	$2.8	$3.7	$6.2	$4.9	$2.3	$2.4	$2.5	$2.7	$2.9	$3.0	$33.5
Retiree Reinsurance Program	$1.3	$2.5	$1.3	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$5.1
Public Plan Start-Up	$0.0	$1.2	$1.9	$1.9	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$5.0
Total Program Costs	$4.0	$7.2	$9.1	$6.5	$61.6	$135.2	$169.0	$186.2	$202.4	$219.7	$1,000.8
Program Offsets											
Employer Pay-or-Play Taxes	$0.0	$0.0	$0.0	$0.0	$6.6	$11.0	$12.1	$12.7	$13.4	$14.0	$69.8
Penalties for Uninsured	$0.0	$0.0	$0.0	$0.0	$2.6	$5.4	$6.2	$6.7	$6.9	$7.1	$35.1
Changes in Other Federal Programs	$0.0	$0.1	$0.1	$0.0	$0.6	$0.9	$1.1	$1.4	$2.1	$2.6	$8.8
Excise Tax on High Cost Plans	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$12.3	$24.4	$36.7
Taxes on Changes in Wages	$1.1	$3.6	$3.7	$0.1	$1.0	$7.8	$7.4	$4.0	-$2.6	-$8.5	$17.6
Total Offsets	$1.1	$3.7	$3.8	$0.1	$10.8	$25.0	$26.9	$24.9	$32.1	$39.7	$168.0
Net Federal Cost	$3.0	$3.5	$5.3	$6.4	$50.8	$110.2	$142.1	$161.3	$170.3	$180.0	$832.8
Medicare and Medicaid Payment Reforms [a/]	$1.5	$0.4	-$12.2	-$21.9	-$46.4	-$54.7	-$66.1	-$83.1	-$99.2	-$116.3	-$498.0
Tax on High-Income [b/]	-$0.6	$9.0	$11.9	$38.1	$50.3	$47.9	$59.5	$64.6	$69.0	$71.0	$420.7
Net Federal Cost of Reform	$5.1	-$5.1	-$18.8	-$53.6	-$45.9	$7.6	$16.5	$13.6	$2.1	-$7.3	-$85.9

Figure 14 (continued)
Changes in Federal Expenditures and Revenues under the Act: 2019-2029
(billions)

	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2020-2029	2010-2029
Public Program Costs												
Medicaid Eligibility Expansion	$95.4	$102.7	$110.6	$119.1	$128.3	$138.2	$148.8	$160.2	$172.5	$185.8	$1,361.6	$1,769.3
Premium Subsidies	$136.0	$146.5	$157.8	$169.9	$182.9	$197.0	$212.1	$228.4	$246.0	$264.9	$1,941.4	$2,491.0
Employer Tax Credit	$3.2	$3.4	$3.3	$3.5	$4.1	$4.3	$4.6	$4.9	$5.2	$5.5	$42.1	$75.6
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	$5.1
Public Plan Start-Up	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$5.0
Total Program Costs	$234.7	$252.7	$271.7	$292.5	$315.3	$339.5	$365.5	$393.5	$423.7	$456.1	$3,345.2	$4,346.0
Program Offsets												
Employer Pay-or-Play Taxes	$14.7	$15.5	$16.2	$17.1	$17.9	$18.8	$19.8	$20.8	$21.9	$23.0	$185.7	$255.6
Penalties for Uninsured	$7.3	$7.6	$7.8	$8.0	$8.3	$8.5	$8.8	$9.0	$9.3	$9.6	$84.2	$119.3
Changes in Other Federal Programs	$2.9	$3.3	$3.7	$4.1	$4.6	$5.3	$5.9	$6.7	$7.6	$8.6	$52.8	$61.6
Excise Tax on High Cost Plans	$31.7	$38.4	$46.6	$56.5	$68.5	$83.1	$98.6	$117.0	$138.9	$164.9	$844.2	$881.0
Taxes on Changes in Wages	-$11.5	-$14.8	-$19.0	-$23.6	-$28.9	-$35.5	-$42.6	-$51.0	-$60.9	-$72.5	-$360.3	-$342.7
Total Offsets	$45.2	$49.9	$55.3	$62.1	$70.4	$80.2	$90.5	$102.6	$116.8	$133.7	$806.7	$974.7
Net Federal Cost	$189.5	$202.8	$216.4	$230.5	$244.9	$259.3	$275.0	$290.9	$306.8	$322.5	$2,538.5	$3,371.3
Medicare and Medicaid Payment Reforms [a/]	-$125.0	-$136.3	-$148.8	-$162.5	-$177.4	-$193.7	-$211.7	-$231.5	-$253.4	-$278.0	-$1,918.5	-$2,416.5
New Tax Revenues [b/]	$72.2	$76.5	$81.2	$86.2	$91.5	$97.2	$103.3	$109.8	$116.8	$124.2	$958.9	$1,379.6
Net Federal Cost of Reform	-$7.6	-$10.1	-$13.7	-$18.3	-$24.1	-$31.7	-$40.0	-$50.4	-$63.4	-$79.7	-$338.8	-$424.7

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

2. Medicaid Expansion

The Medicaid coverage expansions will begin in 2014. As discussed above, we estimate that Medicaid enrollment will increase by 13.0 million people if fully implemented in 2011. These are net enrollment figures reflecting movement of some Medicaid enrollees to other forms of coverage and increased enrollment for newly eligible people.

We estimate that about 1.9 million people will shift from Medicaid to newly offered insurance from an employer (***Figure 15***). Another 514,000 people will leave the roles as the use of income disregards is eliminated. These individuals will be eligible for subsidies through the exchange.

About 12.1 million newly eligible adults will enroll. Of these about 10.1 million (83 percent) will be non-custodial adults. In addition, we estimate that about 3.3 million of those who are now eligible for Medicaid or CHIP who have not enrolled will become covered under the program. These will include currently eligible children who will become enrolled as a newly eligible family member enrolls in the program. Some of these individuals will become enrolled as a consequence of outreach programs.

Figure 15
Changes in Enrollment and Spending for Medicaid under the Act for 2010-2019

	Change in Enrollment if Implemented in 2011 (millions)	Change in Program Costs 2010-2019 (billions)		
		Total Costs	Federal Share	State Share
Current Enrollees Shifting to Private Coverage	(1,861)	-$60.2	-$33.7	-$26.5
Eliminate income disregards	(514)	-$20.3	-$11.4	-$8.9
Enrollment Increases for Currently Eligible				
Children	1,490	$11.9	$8.4	$3.4
Adults	1,804	$49.4	$27.7	$21.7
Total Previously Eligible	3,294	$61.2	$36.1	$25.2
Eligibility Expansions				
Parents	1,964	$44.2	$42.6	$1.6
Non-Custodial Adults	10,115	$308.2	$296.7	$11.5
Total Newly Eligible	12,079	$352.4	$339.3	$13.1
Match For Current Childless Adults	n/a	$0.0	$11.0	-$11.0
Changes in CHIP Spending	n/a	$46.6	$66.3	-$19.7
Net Change in Eligibility	**12,998**	**$379.7**	**$407.6**	**-$27.9**
Other changes except DSH	n/a	-$25.9	-$14.5	-$11.4
DSH Funding	n/a	-$14.0	-$14.0	$0.0
Total Net Change	**12,998**	**$339.9**	**$379.1**	**-$39.3**

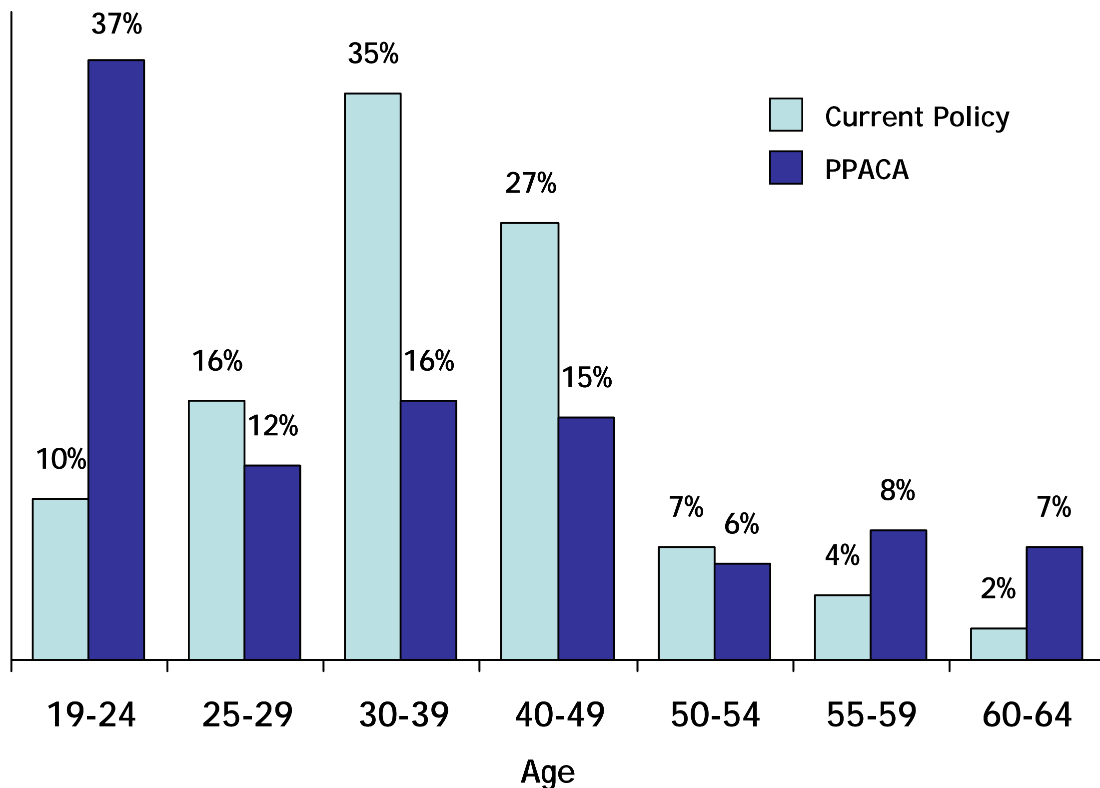
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Total spending for Medicaid will increase by about $379.7 billion due to the various changes in enrollment. However, federal costs will increase by $407.6 billion while state costs will be reduced by $27.9 billion. The savings for states reflect the increase in the federal match for the CHIP program and the increased federal match rate for states already covering non-custodial adults.

In addition, the Act reduces federal Medicaid DSH payments by $14.0 billion. It also reduces spending by 25.9 billion due to increases in Medicaid drug rebates and other changes in benefits and provider payment policy. When these changes are included, total federal spending will increase by $379.1 billion while savings to states will be $39.3 billion.

As shown in ***Figure 16***, the age distribution of newly eligible adults differs from that of parents and caretaker relatives currentlyin the program. About 37 percent of newly enrolled adults will be between the ages of 19 and 24, compared to 10 percent of parents now in the program. However, the newly enrolled will include a greater share of people age 55 to 64. For example, about 7 percent of the newly enrolled will be age 60 to 64 compared with only 2 percent of currently covered parents and caretaker relatives.

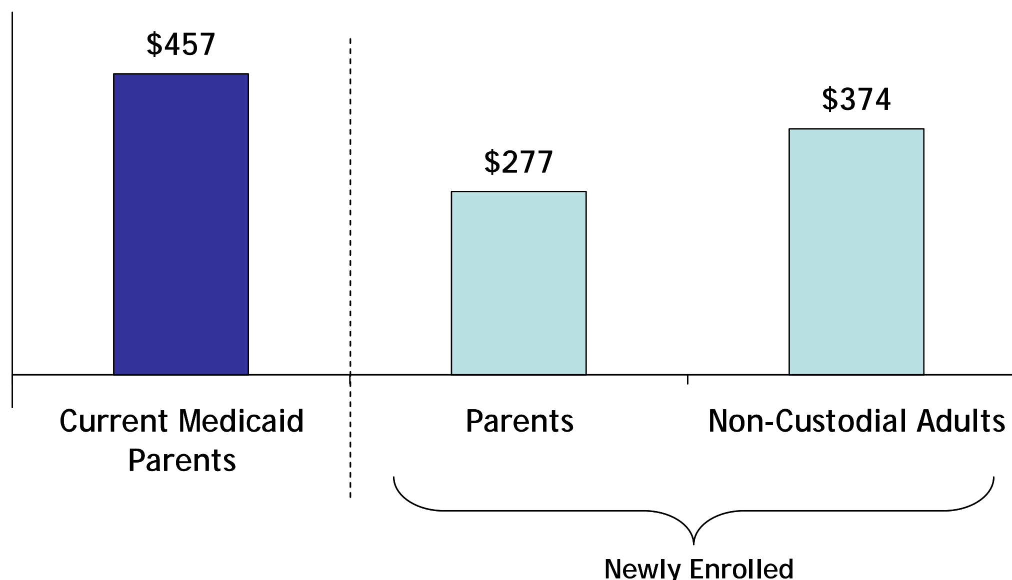
Figure 16
Distribution of Currently Eligible Parents and Newly eligible Adults under PPACA for Medicaid by Age



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

These differences in age composition will result in differing costs for the newly eligible groups. For example, we estimate that in 2011, average costs for parents and caretaker relatives in Medicaid will be about $457 per person per month (PMPM). Due to the lower average age of the newly enrolled, costs will be about $277 PMPM for newly eligible parents and $374 PMPM for newly eligible non-custodial adults (***Figure 17***).

Figure 17
Estimated Average Cost per Person per Month (PMPM) under the Medicaid Expansion



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

Part of the reason why theses groups are less costly is that they tend to exclude pregnant women. This is because all states are already required to cover pregnant women through 133 percent of the FPL. (Thus, many of those adults who become pregnant would likely have been covered under the existing Medicaid program.

3. *Spending Offsets for New Programs*

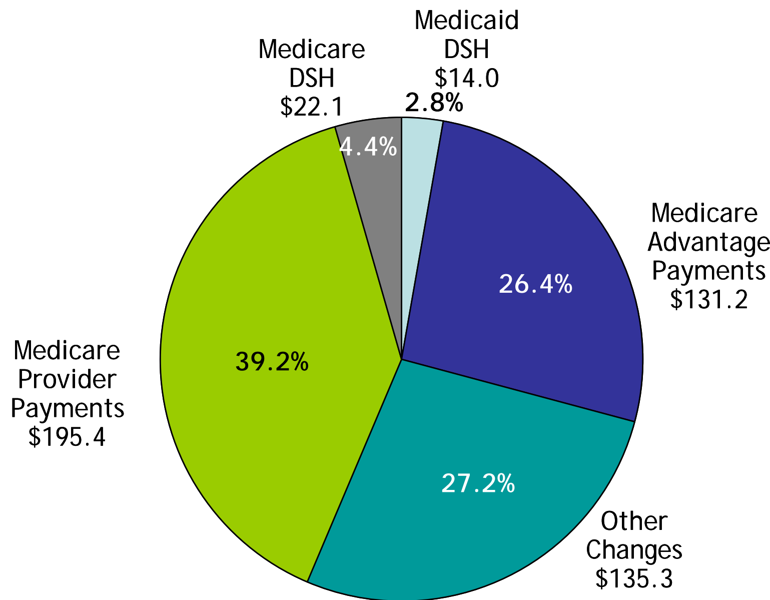
As discussed above, total program offsets over the 2010 through 2019 period will be $167 billion. These include primarily penalties paid by non-insuring employers and individuals who pay the penalty rather than obtain coverage. It also includes revenues from the excise tax on high cost health plans.

There will be a gain in federal income and payroll taxes due to an overall net reduction in employer spending for health benefits over the 2010 through 2019 period of $55.3 billion (discussed in employer impacts section below). This revenue gain is due to increased wage growth resulting from the reduction in employer costs under the Act. This estimate is based on available research indicating that employers will pass on decreases/increases in benefits costs in the form of increased/reduced wage growth, resulting in an associated loss of federal income and payroll tax revenues.

4. Medicare and Medicaid Spending Reductions

The Act is heavily reliant upon reductions in spending under the existing Medicare and Medicaid programs. Total spending reductions for these programs will be $498 billion. Of these, about $195.2 billion (39.2 percent) will be in the form of reductions in the rate of growth in provider payment levels under Medicare and other changes to Medicaid (***Figure 18***). The Act also changes payments to health plans under the Medicare Advantage (MA) program resulting in a reduction in federal costs of $131.2 billion.

Figure 18
Medicare and Medicaid Savings under the Act: 2010-2019 (billions)



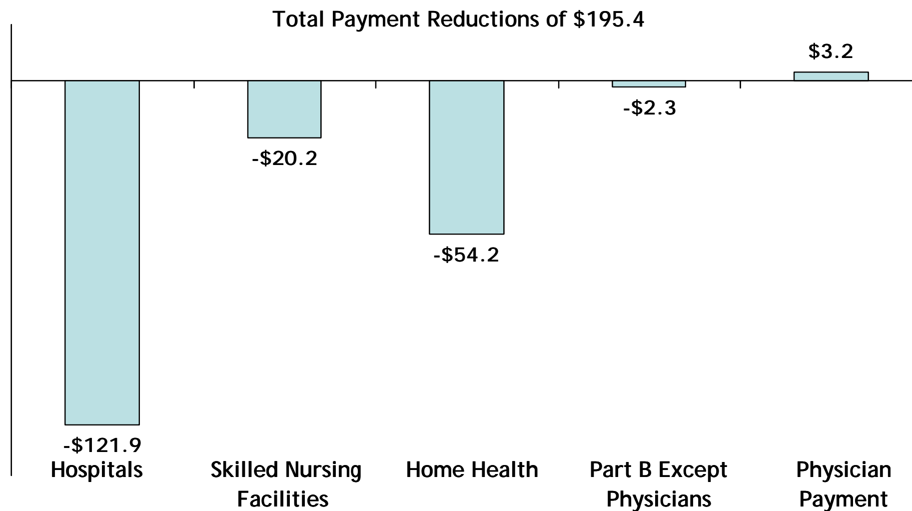
Medicare and Medicaid Spending Reductions = $498.0

Source: Based on estimates provided by the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT).

The Act reduces payments to hospitals under both the Medicare and Medicaid DSH programs. As discussed above, DSH payments are intended to provide additional funding to hospitals that serve a disproportionate share of uninsured and/or Medicaid recipients. Total funding in the two programs is about $20 billion per year. With the reductions in the number of uninsured under reform, some of these funds can be recovered and used to help pay for the program. Total reductions in DSH payments over the 2010 through 2019 period will be about $36.1 billion.

Figure 19 presents the distribution of provider payment reductions by type of provider.

Figure 19
Changes in Provider Payment for Medicare under the Act: 2010-2019 (billions)



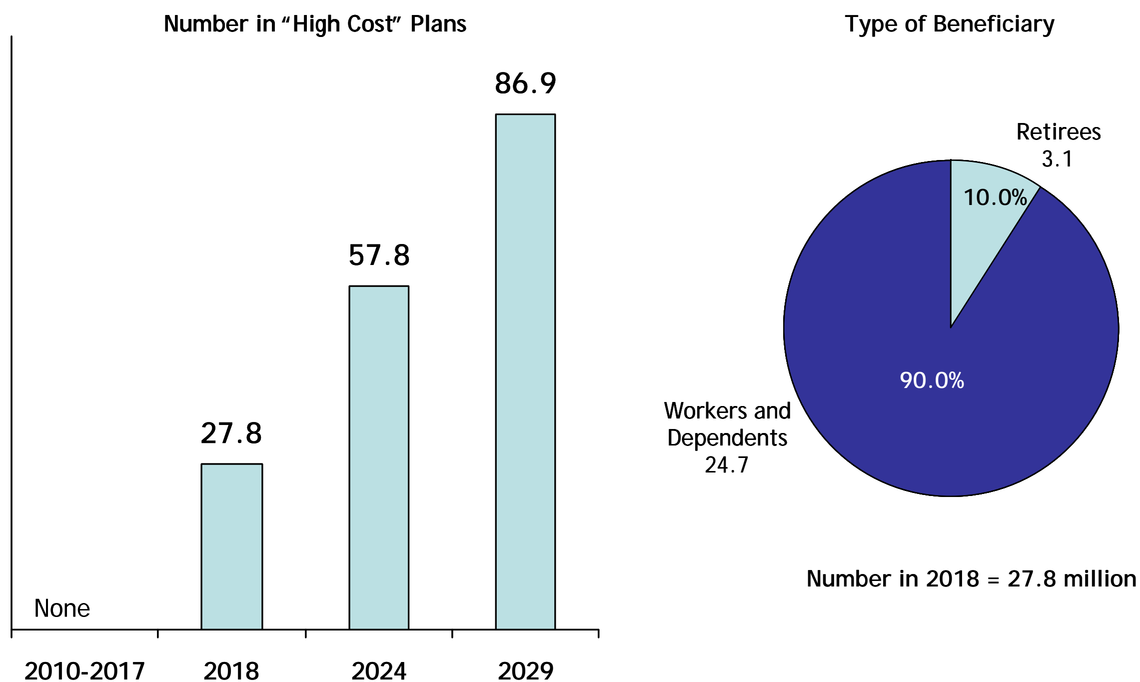
Source: Based on estimates provided by the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT).

The excise tax on high cost plans is the largest of the excise taxes in the Act. As discussed above, insurers will pay a tax equal to 40 percent of the amount by which premiums for an employer health plan exceed $10,200 for individuals and $27,500 for families beginning in 2018. (Higher thresholds apply to workers in high-risk occupations and retirees age 55 to 64.) Insurers pay the excise tax based on data provided by the employer.

The thresholds for the excise tax (i.e., $10,200 for individuals and $27,500 for families) are indexed each year by the CPI. Because health care costs are expected to grow at over 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 20***, we estimate that in 2018, there will be about 27.8 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 plans will grow to 57.8 million by 2019 and 86.9 million by 2029.

Figure 20
Number of People with Policies Subject to the Excise Tax on High-Cost Health Plans under the Act (millions)



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

We estimate that the tax will raise revenues of about $36.7 billion over the 2018 through 2019 period, and $844.2 billion over the 2020 through 2029 period. In fact, the growth in revenues from the tax will 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.

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

We assume that this rise in premiums and prices resulting from these excise taxes will 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 will fall by an amount equal to 20 percent of the dollar amount of these excise tax revenues.[5]

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5 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.

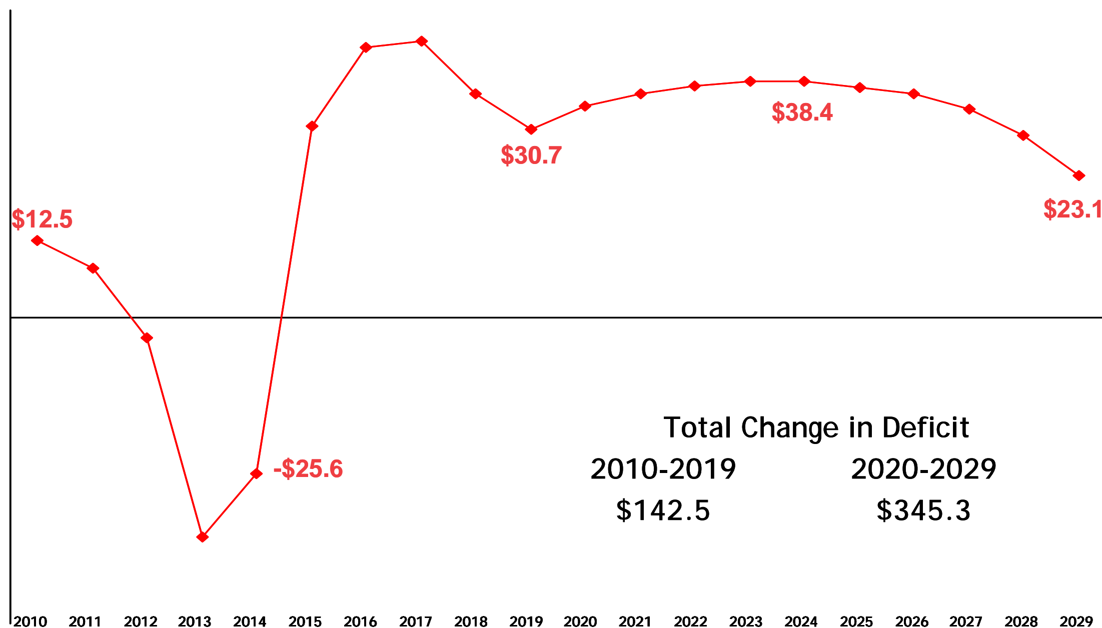
5. Correcting the Sustainable Growth Rate (SGR) Formula

The SGR formula is a methodology for updating annual physician payment levels under Medicare that replaced the volume performance standard in 1997. The formula established annual target spending for physicians. Physician payment levels are reduced if spending exceeds targets due to growth in the volume of services provided. Given the growth in volume of services provided, physician payment levels will be reduced by 21 percent unless Congress acts. Congress has overridden the formula to provide an inflation based adjustment nearly every year since 1997.

The original House Tri-committee bill included a permanent correction to the SGR that will allow for increases in reimbursement based upon cost growth. The CBO estimated that it will add about $228 billion to the cost of the health reform bill over the 2010 through 2019 period. The permanent correction to the SGR is not included in the Act. However, legislators have pledged to include the correction to the SGR in a piece of legislation to be passed separately.

In ***Figure 21***, we present estimates of the impact of health reform including the SGR correction. These data indicate that if the SGR correction were to be included, the federal deficit will increase by $142.5 billion over the 2010 through 2019 period. The deficit will increase by another $345.3 billion in the following decade.

Figure 21
Change in Federal Deficit under the Act: With SGR Correction 2010-2019 (billions)

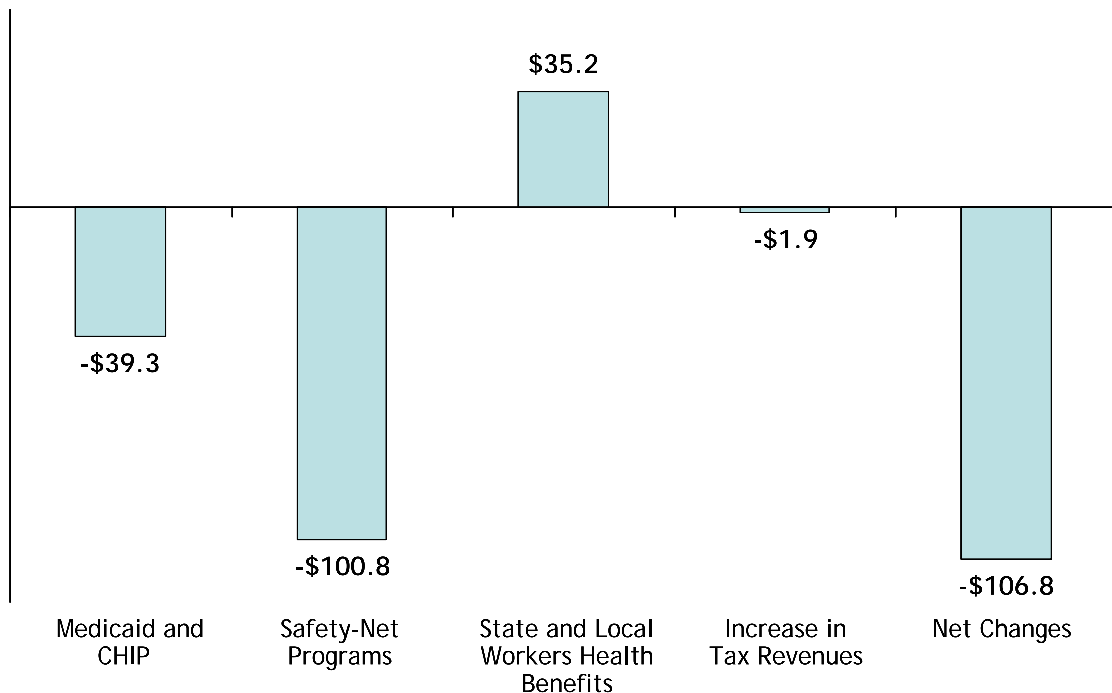


Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

C. Impact on State and Local Governments

The Act will result in net savings to state and local governments of $106.8 billion over the 2010 through 2019 period (***Figure 22***). The largest source of these savings will be reductions in spending under state and local government safety-net programs such as public hospitals and clinics. However these savings will be partly offset with increases in spending for other state benefits programs, including worker health benefits costs.

Figure 22
Impact of the Act on State and Local Government Spending: 2010-2019 (billions)



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

State and local government spending for Medicaid and CHIP benefits will fall by about $39.3 billion over the 2010 through 2019 period despite the expansions in enrollment. This is becausethat the federal government will cover nearly all of the costs for newly eligible people under the Act. As discussed above, the federal government will pay the full cost of covering newly eligible people through 2016, with the FMAP declining to 90 percent by 2019.

The reduction in costs is due to increases in the federal matching rates for certain groups of enrollees. As discussed above, the Act increases the federal matching percentage for CHIP, and includes a phased increase in the federal matching percentage for states that have already covered a portion of the parents and non-custodial adults to be covered under the Act. These savings also reflect reductions in enrollment for people who become covered under newly created employer health plans in response to the employer penalties under the Act.

State and local government spending for employee health benefits will increase by $35.2 billion over the 2010 through 2019 period. This reflects the cost to state and local governments of either covering the workers who do not now have coverage or paying the penalty for uninsured workers. State retiree benefits plans will also qualify for the new reinsurance program for early retirees. Premiums for state and local workers will also reflect the cost of the various excise taxes created under the Act.

However, the primary source of savings for state and local governments will be attributed to safety-net programs that provide care to the uninsured such as free clinics and public hospitals. Due to the expansion in insurance coverage, safety-net providers will be reimbursed for the services that under prior law they would have provided free to the uninsured. Thus, these providers will see an increase in net income, which could be used either to provide additional services or reduce state and local funding for these providers. We estimate these savings will be $101 billion over the 2010 through 2019 period.

We present our estimates of changes in state and local government health spending under the Act for individual years from 2010 through 2029 in *Figure 23*.

Figure 23
Changes in Spending and Revenues for State and Local Governments under the Act: 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	-$0.3	-$1.7	-$1.5	-$1.3	-$1.9	-$2.2	-$9.0	-$6.8	-$7.2	-$7.3	-$39.3	
Savings to Current Safety-net programs	$0.0	$0.0	$0.0	$0.0	-$6.5	-$15.4	-$18.1	-$19.1	-$20.2	-$21.3	-$100.8	
State and Local Government Worker Health Benefits Programs	-$0.6	-$0.8	-$0.1	$1.0	$2.3	$3.5	$4.6	$6.0	$8.5	$10.7	$35.2	
Tax Revenues From Wage Effects (Counted as Offset)	$0.1	$0.4	$0.4	$0.0	$0.1	$0.9	$0.8	$0.4	-$0.3	-$0.9	$1.9	
Net Impact on State and Local Governments	-$1.0	-$2.9	-$2.0	-$0.3	-$6.3	-$15.0	-$23.3	-$20.4	-$18.6	-$17.0	-$106.8	
Percent Change in Spending	-0.2%	-0.6%	-0.4%	-0.1%	-1.1%	-2.5%	-3.6%	-2.9%	-2.5%	-2.1%	-1.8%	
	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	-$6.1	-$6.7	-$7.3	-$8.0	-$8.7	-$9.5	-$10.4	-$11.3	-$12.2	-$13.2	-$93.5	-$132.8
Savings to Current Safety-net Programs	-$22.5	-$23.8	-$25.1	-$26.5	-$28.0	-$29.5	-$31.2	-$32.9	-$34.8	-$36.7	-$291.0	-$391.8
State and Local Government Worker Health Benefits Programs	$12.0	$13.4	$14.9	$16.8	$18.9	$21.3	$24.0	$27.1	$30.6	$34.8	$213.8	$248.9
Tax Revenues From Wage Effects (Counted As Offset)	-$1.3	-$1.6	-$2.1	-$2.6	-$3.2	-$3.9	-$4.7	-$5.7	-$6.8	-$8.1	-$40.0	-$38.1
Net Impact on State and Local Governments	-$15.4	-$15.5	-$15.4	-$15.1	-$14.6	-$13.8	-$12.8	-$11.4	-$9.6	-$7.1	-$130.7	-$237.6
Percent Change in Spending	-1.8%	-1.7%	-1.5%	-1.4%	-1.3%	-1.1%	-1.0%	-0.8%	-0.6%	-0.4%	-1.1%	-1.3%

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

D. Private Employer Impacts

The Act includes provisions that are designed to encourage employers to offer coverage. For example, the Act includes a new tax credit for small employers who start to offer coverage. Also, all employers with 50 or more workers will typically face a penalty if they do not provide the minimum level of benefits for their employees. The penalty applies only to firms with 50 or more workers and is equal to $2,000 per full-time worker (excluding the first 30 workers) if one or more of their full-time workers receives a premium subsidy through the exchange.

However, the availability of the expanded Medicaid program and premium subsidies for lower-wage workers is likely to 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.

As discussed above, we estimate an overall reduction in the number of people with employer sponsored coverage of 2.8 million people. This includes about 17.2 million people in firms that will discontinue their plans under the Act. This loss of coverage is largely offset by an increase in ESI of about 14.4 million people in firms that decide to start offering coverage.

It will take some time before the programs impacts are fully felt. The employer requirements under the act will not be fully implemented until 2014. It may be two or three years before these changes in coverage fully materialize due to lags in responses for employers and workers. However, to illustrate the effect of the program once fully phased-in, we present here estimates of the program's impact on employers for 2011 assuming the law is fully phased-in and that enrollment is fully matured in that year.

1. Employer Health Spending

Total spending for private ESI will be about $452.4 billion in 2011 (***Figure 24*).** This includes the value of the employer share of the cost of health insurance among private employers.[6] Spending for workers and dependents will be $423.6 billion while spending for retiree health benefits will be about $28.8 billion.

We estimate that spending for currently insuring firms will decline by $29.4 billion under the Act if fully implemented in 2011. This reflects a reduction in spending of $40.6 billion due to discontinuations of coverage. [This is computed as total employer spending under prior law ($452.4 billion) less premium payments in the exchange ($24.5 billion) and premiums for non-exchange coverage ($387.3 billion).] These reductions in employer costs also reflect the small employer premium tax credits of $4.7 billion.

These saving will be partly offset by employer penalty payments of about $6.6 billion for employers who discontinue their health plans. The requirement to cover dependents through the age of 26 will increase private employer health spending by $2.5 billion.

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

Figure 24
Changes in Private Employer Health Spending under the Act Assuming Full Implementation in 2011 (billions) [a/]

	Currently Insuring Employers	Currently Non-Insuring Employers	All Employers
Private Employer Spending Under Current Policy			
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 Spending Under the Policy			
Premiums for Employers in the Exchange	$24.5	$3.8	$28.3
Premiums for Employers Out of Exchange	$387.3	$5.9	$389.5
Excise taxes	$5.8	$0.1	$5.9
Cover Dependents to Age 26	$2.5	$0.3	$6.2
Increased Cost Shift	$1.0	$0.0	$1.0
Small Employer Tax Credit	-$4.7	-$1.2	-$5.9
Penalty for Non-Insured Workers	$6.6	$2.0	$8.6
Total Spending Under The Policy	**$423.0**	**$10.9**	**$433.6**
Net Change in Private Employer Spending			
Net Change	**-$29.4**	**$10.9**	**-$18.8**

a/ For illustrative purposes, this scenario Assumes that the Act is fully implemented and enrollment is fully matured in 2011. Excludes the new reinsurance program for retirees, which is not a permanently funded feature of the Act.
Source: Lewin Group Estimates Using the Health Benefits Simulation Model (HBSM).

Employer health spending will also increase by about $5.8 billion due to the new excise taxes under the Act. As discussed above, the Act imposes an excise tax on high-cost health plans. It also creates an excise tax on medical devices, branded prescription medications, and an additional excise tax on fully insured health plans. As discussed above, we assume that the cost of these excise taxes will be passed back to payers in the form of higher premiums.

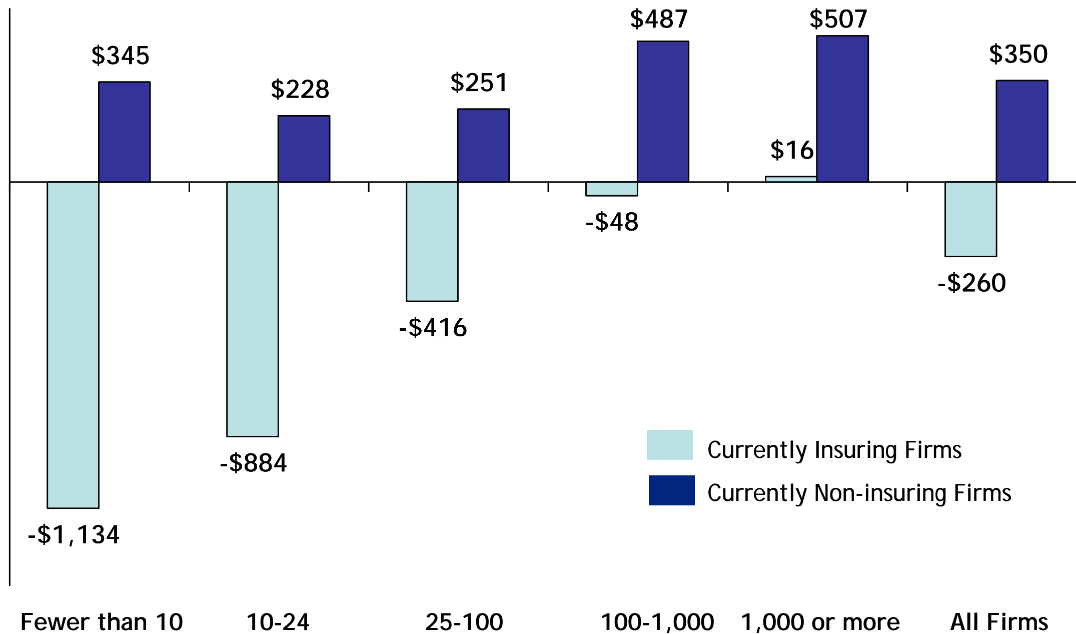
Firms that do not now offer coverage will see new health spending of $10.9 billion if fully implemented in 2011. This reflects the cost of providing insurance in plans that decide to offer ESI ($3.8 billion in the exchange, $5.9 billion out of the exchange) and penalty payments of $2.0 billion for employers who decide to pay the penalty. Costs for firms that do not offer coverage are smaller than might have been expected since most non-insuring employers are small firms that are exempt from the penalty. Small business tax credits for newly insuring employer will be about $1.2 billion.

2. *Impact on Employer Costs by Firm Size and Industry*

Figure 25 presents our estimates of the average change in employer health spending per worker for private employers by firm size assuming the program is fully implemented in 2011. Firms that now offer insurance to at least some of their workers will see a net reduction in health

spending averaging $260 per employee per year. This reflects primarily the reductions in employer coverage under the Act. However, costs will fall by up to an average of $1,100 per worker in firms that take the small employer tax credit.

Figure 25
Change in Private Employer Health Spending Per Worker by Firm Size under the Act: If Fully Implemented in 2011 [a/]



a/ For illustrative purposes, this scenario Assumes that the Act is fully implemented and enrollment is fully matured in 2011. Excludes the new reinsurance program for retirees, which is not a permanently funded feature of the Act.
Source: Lewin Group Estimates Using the Health Benefits Simulation Model (HBSM)

Firms that do not now insure will see an increase in health care costs averaging $350 per worker. This is the average over all non-insuring firms including those that decide to offer coverage and those who do not. Some small firms will also see increased spending even though they are exempt from the penalty. These include firms with older or sicker workers that decide to offer coverage due to reduced premiums resulting from the elimination of medical underwriting.

In ***Figure 26*** we present the changes in spending per worker by industry and current insuring status.

Figure 26
Change in Private Employer Health Spending Per Worker by Industry under the Act: If Fully Implemented in 2011 [a/]

	Insuring Firms		Non-insuring Firms		All Firms	
	Total Change (billions)	Change Per Worker	Total Change (billion)	Change Per Worker	Total Change (billion)	Change Per Worker
Construction	-$2.1	-$346	$1.8	$518	-$0.3	-$27
Manufacturing	-$3.9	-$272	$1.2	$533	-$2.7	-$163
Transportation	-$0.9	-$193	$0.6	$494	-$0.3	-$49
Wholesale Trade	-$0.6	-$167	$0.2	$266	-$0.4	-$97
Retail Trade	-$2.9	-$255	$1.1	$235	-$1.8	-$113
Services	-$8.0	-$232	$4.4	$293	-$3.6	-$72
Finance	-$2.8	-$348	$0.7	$419	-$2.1	-$221
Other	-$1.2	-$349	$0.8	$438	-$0.4	-$77
Total Private	**-$22.3**	**-$260**	**$10.7**	**$350**	**-$11.6**	**-$99**

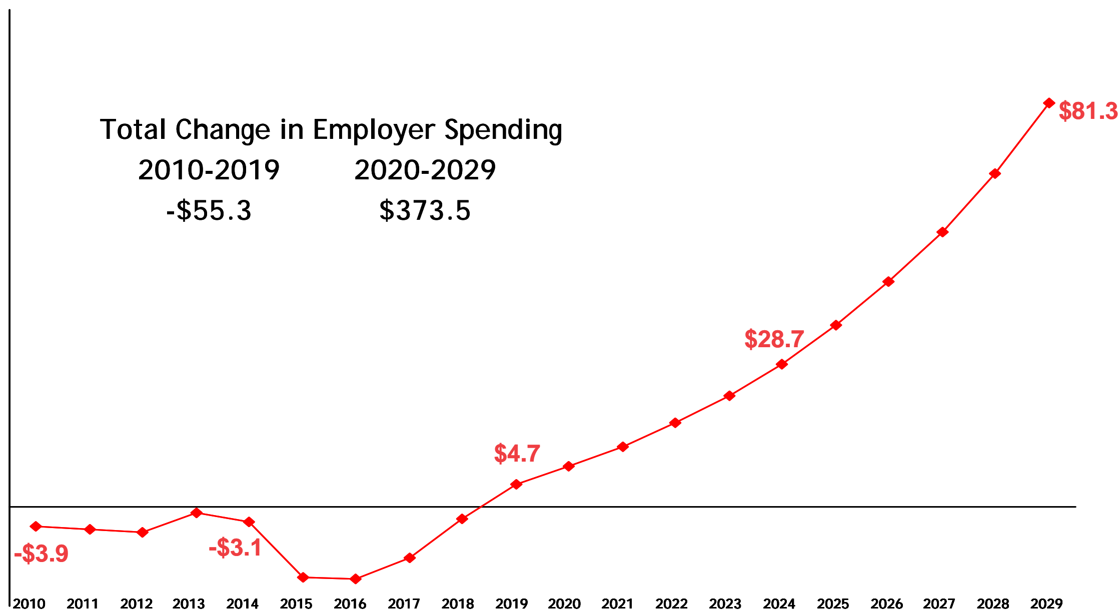
a/ For illustrative purposes, this scenario Assumes that the Act is fully implemented and enrollment is fully matured in 2011. Excludes the new reinsurance program for retirees, which is not a permanently funded feature of the Act.
Source: Lewin Group Estimates Using the Health Benefits Simulation Model (HBSM)

3. Long-Term Impact on Private Employer Spending

In ***Figure 27*** we present our estimates of the net change in employer health spending between 2010 and 2029 under the Act. These year by year cost estimates reflect the actual timeline for implementation of the Act and expected lags in consumer responses concerning enrollment. These estimates are consistent with the year-by-year estimates presented above for employers and the state and federal governments.

Employer health spending will decline by about $55.3 billion over the 2010 through 2019 period (***Figure 27***). Most of these savings are attributed to discontinuations of health plans. However, employer costs will generally increase after 2018. Total private employer health spending will increase by $373.5 billion over the 2020 through 2029 period. This reflects the growing amount of excise taxes that employers will pay for "high-cost" health plans. (As discussed above the thresholds ($10,200 single and $27,500 family) will be indexed at about half the rate of growth in health care costs resulting in increasing numbers of plans subject to the tax.)

Figure 27
Change in Private Employer Health Spending under the Act: 2010-2019 (billions



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

4. *Employment Effects*

The Act creates a new obligation for employers to contribute to the cost of covering their workers, either by providing insurance or paying a tax. As discussed above, we expect employers to pass-on increases in health care costs to workers in the form of slowed wage growth, while passing on savings in worker health care costs as increased wage growth. When wage reductions for those experiencing increased health benefits costs fully offset the increase in health care costs, there will be little employment effect. However, when wage adjustments are not able to fully offset the effects of higher health care costs because of a binding minimum wage, there will be employment effects.

We define workers employed at the minimum wage to be the group that is "vulnerable" to employment effects, which we define to be full-time workers who are at or near the minimum wage (we assume $7.00 per hour) who would not have ESI under prior law. We estimated the loss of employment for this group based upon studies of the effect of the minimum wage on employment. The elasticity estimates of the demand for labor are typically small: in the range of -0.1 to -0.3.[7] These estimates are based upon changes in aggregate employment given a change in the minimum wage.[8]

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[7] See, for example, Charles Brown, Curtis Gilroy, and Andrew Kohen, "The Effects of the Minimum Wage on Employment and Unemployment," Journal of Economic Literature, June, 1982; and Brown, Gilroy and Kohen, "Time Series Evidence of the Effect of the Minimum Wage on Youth Employment," Journal of Human Resources, Winter, 1983. More recent evidence is summarized in Jacob Klerman and Dana Goldman, "Job Loss Due to Health

We estimate that there will be a loss of employment among the vulnerable (i.e., low-wage) population of between 157,300 and 366,200 people if the Act were fully implemented in 2011. ***Figure 28*** presents these estimates of job-loss by firm size and industry. The loss of wages for these workers is reflected in the wage effect estimates presented in the following sections.

Figure 28
Estimated Job Loses Under the Act under Alternative Assumptions: If Implemented in 2011 (thousands) [a/,b/]

	Low Range Estimate	High Range Estimate
Firm Size		
Under 10	0.0	0.0
10-50	0.0	0.0
51-99	11.0	27.3
100-499	39.2	86.5
500-999	13.0	32.4
1000-4999	20.0	49.8
5000 +	39.4	91.1
Government	34.7	79.1
Industry		
Construction	24.2	50.4
Manufacturing	9.8	24.2
Transportation	6.5	16.2
Wholesale Trade	1.8	4.4
Retail Trade	15.1	37.3
Services	52.7	125.4
Finance	4.4	10.7
Other	8.2	18.4
Government	34.7	79.1
Total Workers	**157.3**	**366.2**

a/ Assumes an employment elasticity for minimum-wage workers ranging from -0.1 to -0.3, adjusted for use in micro-data simulations.
b/ 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).

Care Reform," (Rand Corporation) Statement prepared for the Subcommittee on Health of the House Committee on Ways and Means, November 4, 1993.

8 These elasticity estimates were transformed so that they could be applied to the vulnerable worker population only as represented in HBSM, resulting in elasticity assumptions of -0.2 and -0.5.

E. Impact on Consumers

Under prior law, families will spend an average of about $4,193 per family for health care in 2011 (***Figure 29)***. 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 29
Average Family Health Spending by Family Income under Prior Law in 2011

	Number of Families (thousands)	Spending under Prior 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).

We estimated the effect of the Act on consumers assuming the program is fully implemented and that enrollment if fully matured in 2011. As discussed above, the coverage expansions will not begin until 2014, and we expect that it will take another two to three years for employers and consumers to respond to the new features of the law. For illustrative purposes, we present here estimates of the impact of the Act on consumers assuming that the program is fully implemented and that enrollment is fully matured in 2011.[9]

[9] Our year by year cost estimates reflect the actual timeline for implementation of the Act and lags in consumer responses concerning enrollment.

1. Changes in Family Health Spending

We estimate that if fully implemented in 2011, average annual health spending will increase by about $86 per family under the Act (***Figure 30***). However, lower-income families will see net savings while people at higher income levels will see increases in spending. ***Figure 30*** shows the changes in average family health spending due to changes in premiums, subsidies, out-of-pocket spending and penalty payments.

Figure 30
Changes in Average Family Health Spending under the Act by Income Assuming Full Implementation in 2011 [a/]

	Number of Families	Changes in Family Spending Under the Act				
		Change in Premiums	Change in Out-of-Pocket	Penalty payments	After tax Wage Effects	Net Change in Average Spending
Families by Family income						
Under $10,000	13,257	-$212	-$170	$1	$46	-$427
$10,000-$19,999	15,579	-$88	-$116	$15	$34	-$223
$20,000-$29,999	14,716	-$151	$21	$47	$113	-$196
$30,000-$39,999	14,434	-$147	$84	$59	$115	-$119
$40,000-$49,999	11,759	-$104	$124	$45	$20	$45
$50,000-$74,999	21,278	$25	$225	$47	$51	$246
$75,000-$99,999	15,403	$110	$174	$79	$26	$337
$100,000-$149,999	16,203	$127	$195	$111	$8	$425
$150,000 or More	13,135	$207	$205	$123	-$42	$577
All Families						
All Families	135,765	-$20	$90	$59	$43	$86

a/ For illustrative purposes, this scenario assumes that the Act is fully implemented and enrollment is fully matured in 2011. Estimates exclude the effect of the increase in the HI payroll tax for people with incomes over $250,000.
b/Changes in employer health care costs for active employees and dependents are passed back to workers in the form of increased/decreased wage growth.
Source: Lewin Group Estimates Using the Health Benefits Simulation Model (HBSM).

We estimate an increase in after-tax wages due to the savings we estimate for employers. As discussed above, 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.[10] Thus, a reduction in employer costs is passed back to workers as increased

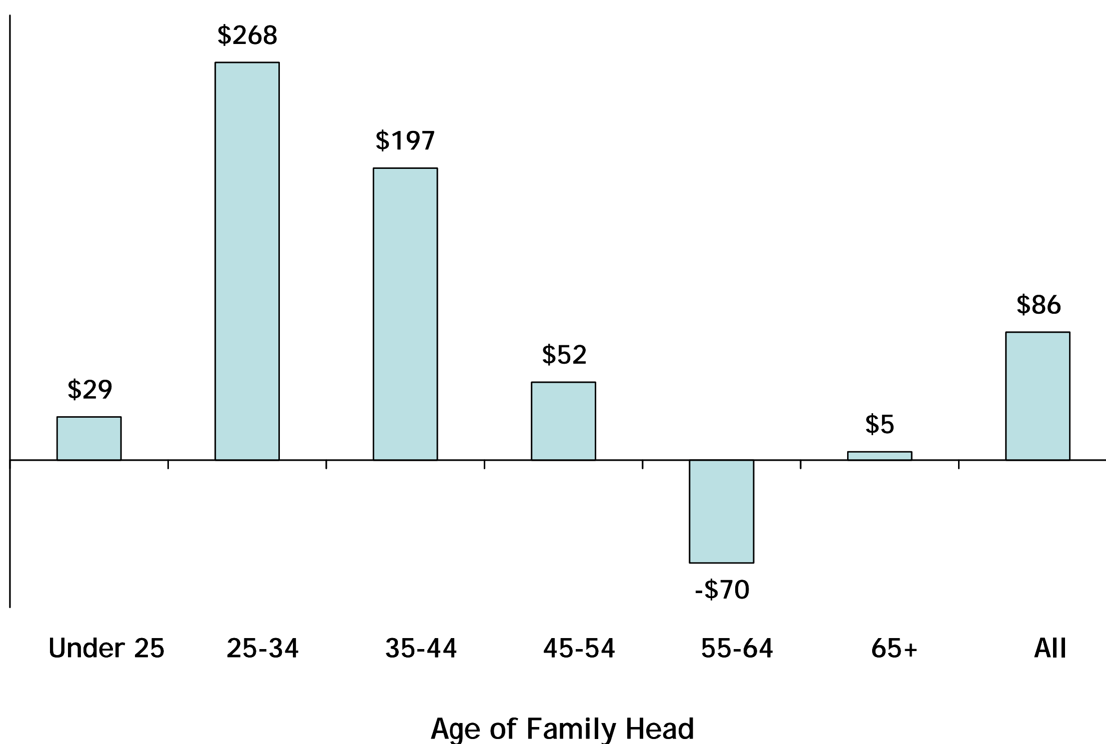
[10] See, for example, James Heckman, "What Has Been Learned About Labor Supply in the Past Twenty years?" American Economic Review, (May 1993).

wage growth over time.[11] In this analysis, we treat the reduction in wages due to increases in employer costs as an increase in family health care spending.

2. Demographic Variation

While families overall will see an increase in health care spending, the change in spending will vary widely with the age of the family head (***Figure 31***). Annual health spending will increase by $268 per family headed by someone age 25 to 34. The increase in spending declines as age increases.

Figure 31
Changes in Average Family Health Spending by Age of Family Head: Assuming Full Implementation in 2011[a/]



a/ For illustrative purposes, this scenario assumes that the Act is fully implemented and enrollment is fully matured in 2011. Estimates exclude the HI tax increase for people with incomes above $250,000.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Among families headed by someone age 55 to 64, health spending will decline by $70 per family. This reflects that the Act limits premium variation to a 3:1 ratio.

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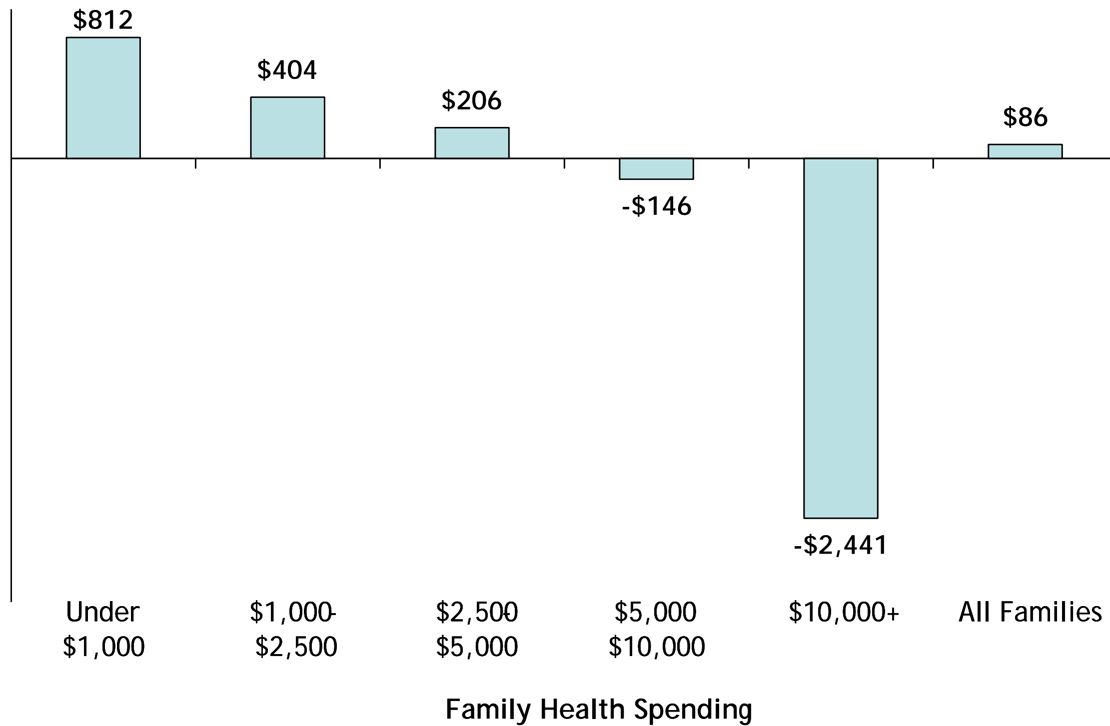
[11] See, for example, Jonathan Gruber and Alan B. Kreuger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers Compensation Insurance," in Tax Policy and the Economy (1991); Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," American Economic Review, (forthcoming); and Lawrence H. Summers, "Some Simple Economics of Mandated Benefits," American Economic Review (May 1989).

Savings will be greatest for families that will have had high health care expenses under prior law. For people who will have spent $10,000 or more out-of-pocket, savings will average $2,441 per family under the Act (***Figure** 32*). By contrast, families that will have had under $1,000 in spending under prior law will see increases in spending averaging $812 per family.

Figure 32
Change in Average Family Health Spending by Family Spending under the Act: Assuming Full Implementation in 2011 [a/]



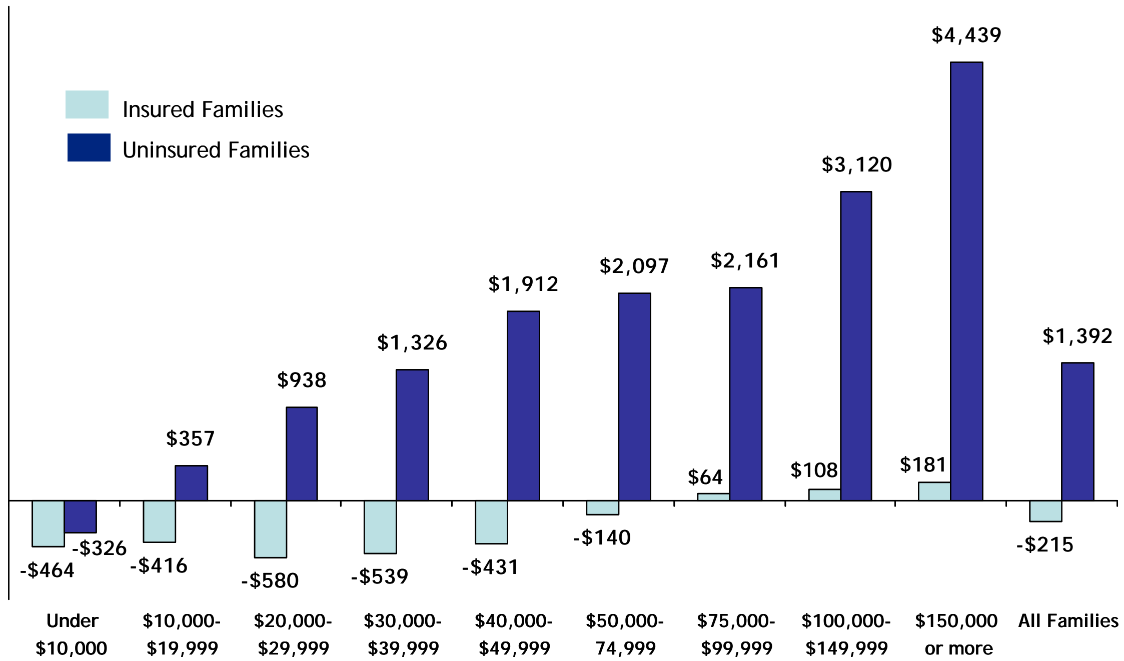
a/ For illustrative purposes, this scenario assumes that the Act is fully implemented and enrollment is fully matured in 2011. Estimates exclude the HI tax increase for people with incomes above $250,000.
aSource: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The impact of the Act on families will vary with the current insured status of family members. Families where all members will have been insured under prior law will have average annual savings of $215 per family (***Figure** 33*). Insured families with annual incomes of less than $50,000 per year will on average see savings, while higher income families will tend to see increases in spending.

However, spending for families with one or more uninsured members prior to the Act will increase under the Act. On average, families with uninsured members under prior law will pay an additional $1,392 per family (***Figure** 33*). 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 will be greater than what they save in out-of-pocket health care costs by having coverage.

Figure 33
Changes in Average Family Health Spending For Currently Insured Families under the Act in 2011[a/]



a/ For illustrative purposes, this scenario assumes that the Act is fully implemented and enrollment is fully matured in 2011. Estimates exclude the HI tax increase for people with incomes above $250,000.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

F. Impact on National Health Spending

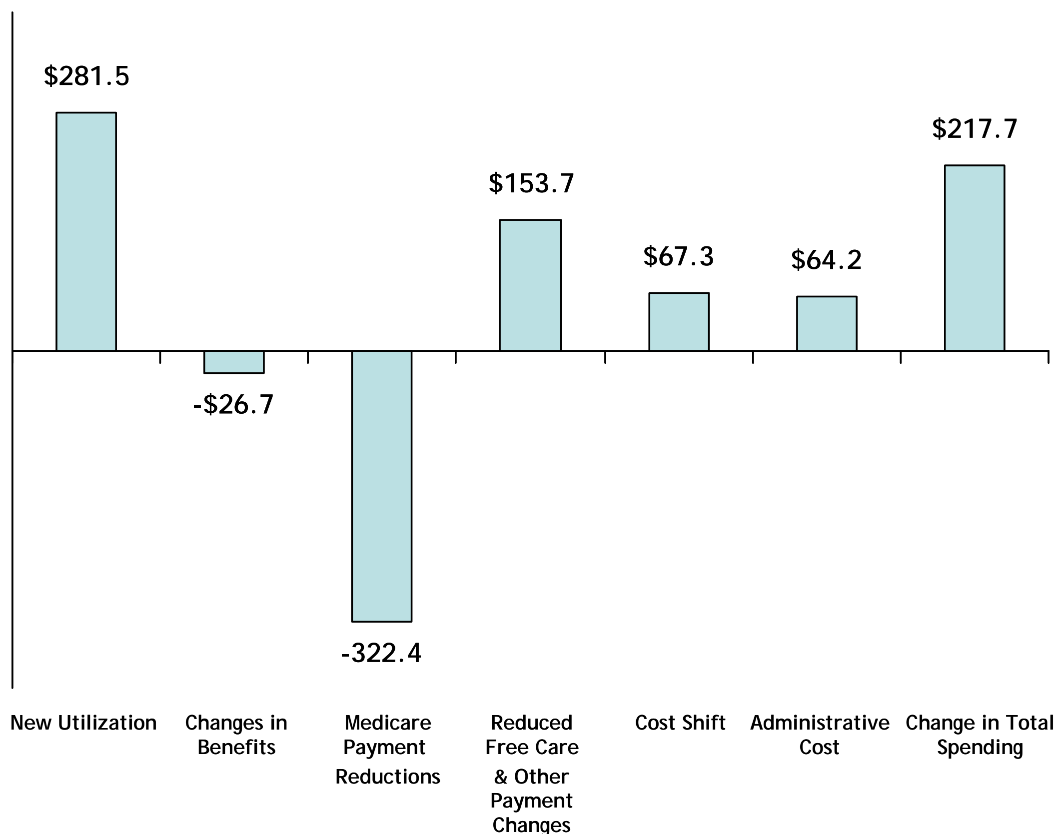
The actuaries of the CMS estimate that national health spending will reach $2.70 trillion in 2011. This includes expenditures for health services, prescription drugs, medical equipment, public health, research and construction. It includes the amounts spent by all payer groups including the federal government, state and local governments, employers and families.

In this analysis, we estimated the change in total health spending in the U.S., for all payer sources for 2010 through 2029.

1. Sources of Changes in National Health Spending

We estimate that national health spending over the 2010 through 2019 period will increase by $217.7 billion under the Act (***Figure 34***). We estimate an overall increase in utilization of health services of $281.5 billion for the newly insured and those obtaining improved coverage under the Act.

Figure 34
Changes in National Health Spending under the Act: 2010-2019 (billions)



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

We estimate savings of about $26.7 billion under the Act due to changes in benefits over the 2010 through 2019 period. These include the effects of increased competition in the exchanges and benefits reductions in response to the increased prices resulting from the excise taxes under

the Act. It also reflects savings resulting from the Medicare Advisory Commission and changes in utilization of services due to the loss of supplemental benefits under the MA program.

The amounts paid to providers under the Medicare program will be reduced by $322.4 billion due to the various changes in Medicare under the Act. However, there will be several changes that will increase provider incomes under the Act by about $153.7 billion.

For example, due to the expansions in coverage under the Act, providers will be paid for many of the services that they will have provided free to uninsured people under prior law (i.e., reduced uncompensated care). There also will be movement of some Medicaid eligible individuals to private insurance where provider payment levels are higher. The Act also increases Medicaid payments for primary care for a three year period.

Cost shifting under the Act will be less than some have speculated. The theory behind cost shifting is that providers must increase what they charge to privately insured people to recover the cost of uncompensated care and underpayments for care under public programs like Medicaid and Medicare. However, the reductions in provider revenues for these programs will be largely offset by reductions in uncompensated care and other changes in reimbursement. This will greatly offset pressures to cost-shift due to reductions in program payments.

The available research indicates that providers shift about 40 percent of any net change in uncompensated care and payment shortfalls under public programs to privately insured people. [12,13,14] Based upon this assumption, we estimate that total cost shifting over the 2010 through 2019 period will be about $67.3 billion under the Act.

System-wide administrative costs will increase by about $64.2 billion over the 2010 through 2019 period. These include the cost of administering private insurance to newly covered people, the cost of administering coverage under Medicaid and the cost of processing eligibility for premium subsidies under the Act.

2. *Long-term National Health Spending Growth*

The Act will result in a net-increase in national health expenditures. As discussed above, national health spending over the 2010 through 2019 period will increase by $217.7 billion under Act, which is and increase of six-tenths of one percent. Spending will continue to grow in the following decade as well. Total health spending over the 2020 through 2029 period will increase by another $343.9 billion (***Figure 35***).

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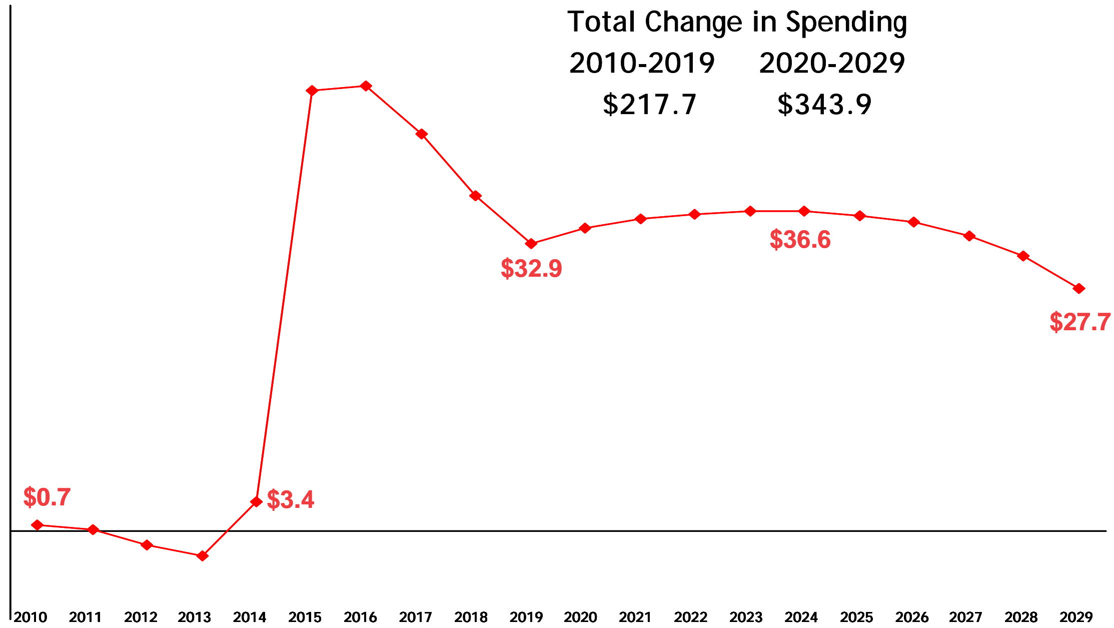
[12] Dranove, David, "Pricing by Non-Profit Institutions: The Case of Hospital Cost Shifting," *Journal of Health Economics*, Vol. 7, No. 1 (March 1998); and Sloan, Frank and Becker, Edward, "Cross-Subsidies and Payment for Hospital Care," *Journal of Health Politics, Policy and Law*, vol. 8., No. 4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

[13] 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)

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

Figure 35
Change in National Health Spending under the Act 2010-2019 (billions)



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

However, the net increase in national health spending will hold steady at $30 billion to $35 billion per year, reflecting a small reduction in the rate of growth in health spending due to the Act. This reflects the expected growth in payment for high cost plans and an extension of the Medicare provider payment reductions into the following decade.

G. Impact on Hospital and Physician Income

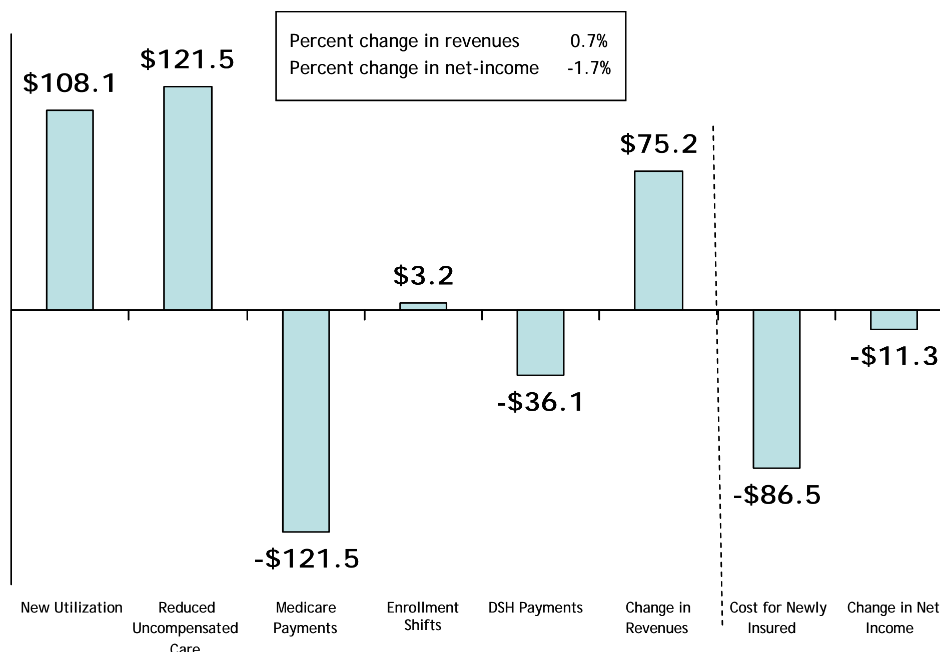
The impact of the Act on provider incomes can be assessed only by looking at the many factors that will affect revenues and net income. While the reductions in reimbursement under public programs are quite large, they are partly offset by new utilization of health services and reductions in uncompensated care. In this section, we focus on the changes in revenues and net income for providers over the 2010 through 2019 period.

In this analysis, we assume that provider payment levels by the public plan and private plans in the exchanges are similar to current commercial payment levels and that future commercial payment levels do not increase or decrease from what is currently projected. As described above, we assume that about 40 percent of the change in provider payments will be passed on the private plans in the form of higher charges through cost shifting. The following analyses are prior to accounting for any cost shifting that may occur due to changes in provider reimbursement.

1. Hospital Revenues and Net Income

We estimate that there will be an overall increase in hospital revenues of $75.2 billion under the Act, despite reductions in hospital payment under Medicare (***Figure 36***). We estimate that newly insured people will use more health services resulting in $108.1 billion more in revenues. This reflects our modeling assumption that health services utilization for newly insured people will adjust to the levels reported by insured people with similar demographic and health status characteristics (age, gender, health status and income).

Figure 36
Change in Hospital Revenues and Net-Income under the Act: 2010-2019 (billions)



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

Hospital revenue for the new utilization is based on payment levels for the programs that newly insured people enroll. About 40 percent of the newly insured are covered through the Medicaid expansion, which we assume reimburses hospitals consistent with current reimbursement levels that are known to be less than cost. On the other hand, and 60 percent of newly insured people will be covered under private plans in the exchange, which we assume will reimburse hospitals at current commercial levels that are above costs.

We estimate a reduction in uncompensated care of about $121.5 billion for hospitals. This means that hospitals will be paid over $121 billion for care that they will otherwise have provided free to uninsured and underinsured people. We count these payments as new revenues.

As discussed above, hospital payments for services provided to people covered under Medicare will be reduced by about $121.5 billion. In addition, there will be shifts of coverage between Medicaid and private insurance that will affect payment levels for the services provided. This will result in net revenue increase of $3.2 billion.

The Act also reduced Disproportionate Share Hospital (DSH) payments under Medicare and Medicaid. Medicare and Medicaid both provide about $10.0 billion each per year in additional funds to hospitals serving a disproportionate share of the uninsured and people covered under Medicaid. The Act will reduce payments under these programs as the number of uninsured is reduced. DSH reductions over the 2010 through 2019 period will be $36.1 billion.

The net effect of these changes will be an actual increase in hospital revenues over the 2010 through 2019 period of $75.2 billion under the Act. When we subtract the cost of providing the new services for newly covered people, we estimate a reduction in hospital net income over that period of about $11.3 billion.[15]

2. Physician Revenues and Net Income

We estimate an overall increase in physician income under the Act 129.8 billion, despite the fact that it does not include a correction the Sustainable Growth Rate (SGR) formula (***Figure 37***).

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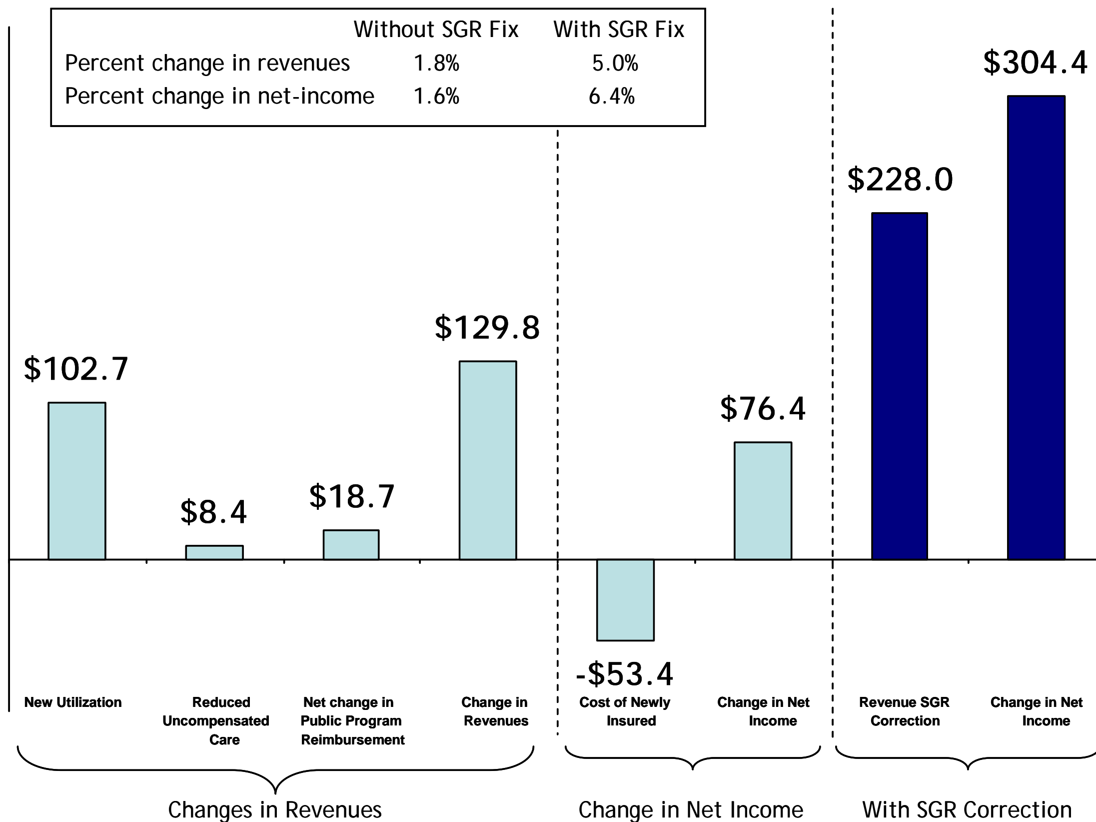
15 We assume that the marginal cost of providing these services is equal to 80 percent of average costs, which is the assumption used by CMS in calculating outlier payments under the Medicare hospital inpatient prospective payment system (IPPS).

Figure 37
Change in Physician Revenues and Net-Income under the Act: 2010-2019 (billions)



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

As discussed above we expect newly insured people will use more health services once they become covered. We estimate that utilization of physician services will increase by about $102.7 billion under the Act. This estimate reflects Medicaid the payment levels for the portion of newly insured people covered under that program and commercial payment levels for those who become covered under private insurance. As discussed above, our key assumption is that utilization of services for newly insured people adjusts to the levels reported by insured individuals with similar age, gender, health status and income characteristics.

Physicians also will be paid for services formerly provided free to uninsured people resulting in revenues of $8.4 billion. There will be an increase in reimbursement for people who shift from Medicaid to private coverage, and payment rates for Medicare primary care services will be increased for a three year period under the Act. These factors will add 18.7 billion in revenues for physicians.

Taking all of these changes into account, physician revenues will increase by about $129.8 billion under the Act. After we subtract the cost of providing the new services to newly covered

people, we estimate an overall increase in physician net income of $76.4 billion.[16] However, the impact is likely to vary widely across physicians by specialty, patient mix, geographic region and other factors.

The CBO estimates that correcting the SGR formula will increase federal costs by about $228 billion over the 2010 through 2019 period. If the SGR correction is adopted, physician net income will increase by a total of $304.4 billion over the ten year period.

[16] We estimate that practice expenses accounts for about 65 percent of net patient revenues for physicians and we assume that the marginal cost of providing these additional services is equal to 80 percent of average costs.