July 28, 2009

To: Interested Parties
From: Center for Health Policy Studies, The Heritage Foundation
Re: The Impact of the American Affordable Health Choices Act on the **State of Montana**

The Heritage Foundation commissioned The Lewin Group, a highly respected health care policy and management consulting firm, to examine the impact of the American Affordable Health Choices Act of 2009 (H.R. 3200). Among other provisions, the bill would create a new public plan, modeled on Medicare, to compete with private health plans in a newly established health insurance exchange. In addition to national results, Lewin produced state level impacts of the draft legislation for a select group of states, including **Montana**.

In its analysis of **Montana**, Lewin presents data estimating the impact of the bill, assuming eligibility to the exchange is open to all employers beginning in year three, on sources of coverage and potential changes in physician and hospital incomes. The highlights of the report on **Montana** include:

Effects on Private Coverage and the Uninsured

- ***52 percent of privately insured Montana residents would transition out of private insurance.*** Of the estimated 489,200 Montana residents with private health insurance, there would be a decline of 256,700 people with private coverage.
- ***62 percent of Montana residents with employer-based coverage would lose their current insurance.*** Of the estimated 426,900 Montana residents with employer-based coverage, 265,400 people would be shifted out of their current employer-based plan.
- ***80 percent of Montana residents in a health insurance exchange would end up in the public plan.*** Of the estimated 414,100 Montana residents who would obtain coverage through an exchange, 330,500 would be covered by the public plan.
- ***32 percent of the uninsured in Montana would still lack coverage.*** Of the estimated 180,800 Montana residents without health insurance, the legislation would only reduce the uninsured by 123,200, leaving 57,600 Montana residents without coverage.

Effects on Physicians and Hospitals

- ***Physicians in Montana could see their net annual income decline by $36.6 million, an average loss in income of $13,877 per physician.*** Of this net loss in income, $129.7 million is attributable to the public plan using Medicare-based payments. Today, Medicare physician payments in Montana are 76 percent of private payments.
- ***Hospitals in Montana could have their net annual income fall by about $268.5 million, with hospital total margins dropping to -4 percent.*** This loss in hospital income, greater than total hospital margins, is overwhelmingly attributable to the public plan using Medicare-based payments. Today, Medicare hospital payments in Montana are 64 percent of private payments.

###

3130 Fairview Park Drive, Suite 800 | Falls Church, VA 22042 | phone: (703) 269-5500 | fax: (703) 269-5501 | www.lewin.com

memorandum

Date: July 23, 2009

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

From: John Sheils and Randy Haught

Re: Analysis of the Draft of the American Affordable Health Choices Act of 2009 for Montana

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

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

In this memorandum, we present estimates of the impact of the Act on sources of insurance coverage and provider incomes in the state of Montana. We present estimates for four

---

[1] 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.

variations on eligibility for the newly created exchange. Our results are presented in the following sections:

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

A. Insurance Exchanges and the Public Plan

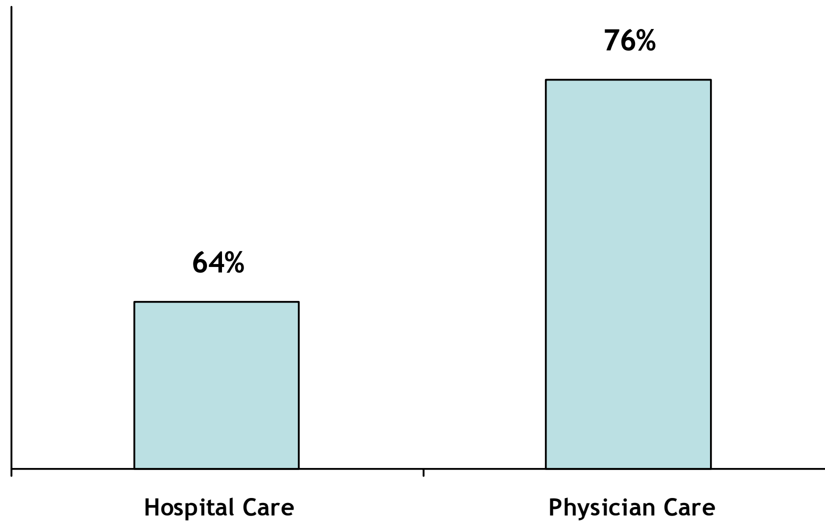
The Act would establish a nationwide network of health insurance exchanges. The exchange would provide consumers with a selection of health insurance plans competing on the basis of price and quality. It is designed to provide consumers with a transparent marketplace for coverage that features consumer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

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

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

The public plan would pay health care providers using the Medicare payment methodology. As shown in ***Figure 1***, we estimate Medicare payments to hospitals in Montana are equal to only about 64 percent for what private insurers pay for the same services. Medicare physician payments are equal to only about 76 percent of what is paid by private insurers in Montana for comparable services. Under the Act, physicians would be paid at Medicare rates plus five percent.

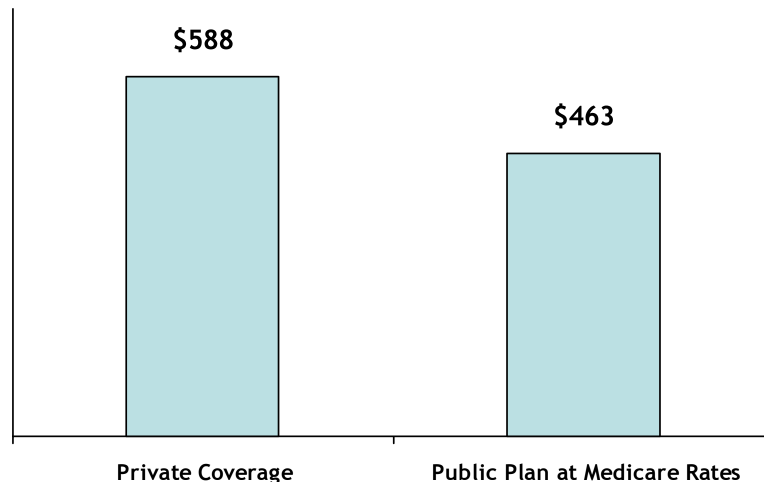
Figure 1
Medicare Provider Payments as a Percent of Private Payer Rates in Montana



Source: Lewin Group Estimates.

Because Medicare pays Montana providers substantially less than private insurers, premiums for the public plan would be substantially less than comparable coverage in a private plan. For illustrative purposes, we present an estimate of premiums per policy holder (i.e., average across individual and family policies) using Medicare payment levels. We estimate that average premiums under the "enhanced" benefits package would be $588 per month for private coverage compared to $463 per month under the public plan in 2011 (***Figure 2***). This represents a savings of about 21 percent.

Figure 2
Illustrative Monthly Premium per Policy Holder under Private Insurance and the Public Plan Under the Act in Montana in 2011



a/ Premiums for policy holders with private coverage under current law. Premiums are an average across family and individual policies.
b/ Assumes provider payment levels are set at Medicare payment levels, with physicians and other professionals receiving an additional 5 percent if they accept patients from both the public plan and Medicare.
Source: Lewin Group Estimates Using the Health Benefits Simulation Model (HBSM)

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

B. Medicare Payment Reforms

The Act includes over 80 sections that alter Medicare provider payment policies for virtually all types of providers of health services including physicians, hospitals, home health agencies, skilled nursing facilities, rehabilitation hospitals and other health care practitioners. Several of these changes are designed to encourage improved quality and efficiency such as bundled payments and quality related payments such as pay-for-performance.

The Act also permanently replaces the "sustainable growth rate" (SGR) formula for Medicare payments to physicians and other health practitioners. This averts the 21 percent reduction to payment levels that is scheduled to occur under current law. However, Congress is expected to act to prevent these payment reductions as they have done in each of the past several years,

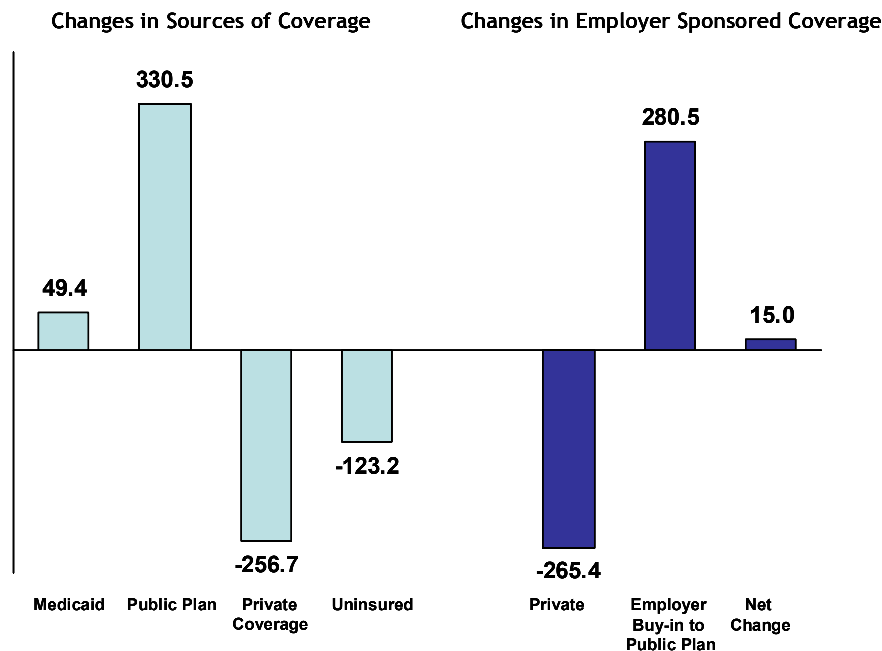
regardless of health reform. This is also assumed in President Obama's proposed budget. Consequently, we present our physician-impacts estimates with and without the effects of replacing the SGR.

Total reductions in Medicare payments to providers under the bill would be $218 billion from 2010 through 2019. We estimate the impact on providers in Montana would be about $745 million over the same ten-year period.

C. Coverage Effects

We estimate that there will be about 180,800 uninsured people in Montana in 2011. ***Figure 3*** presents our estimates of the impact of the Act on coverage assuming the exchange is extended to all firms as is permitted under the bill. Once the program is implemented, we estimate that the number of uninsured people would be reduced by 123,200 people . Enrollment in the expanded Medicaid program would increase by 49,400 people. This includes about 58,000 newly enrolled people, less about 8,700 current enrollees who would become covered by employers who start to offer coverage in response to the mandate.

Figure 3
Changes in Sources of Coverage under the American Affordable Health Choices Act Assuming Full Implementation in Montana in 2011 (1,000s)



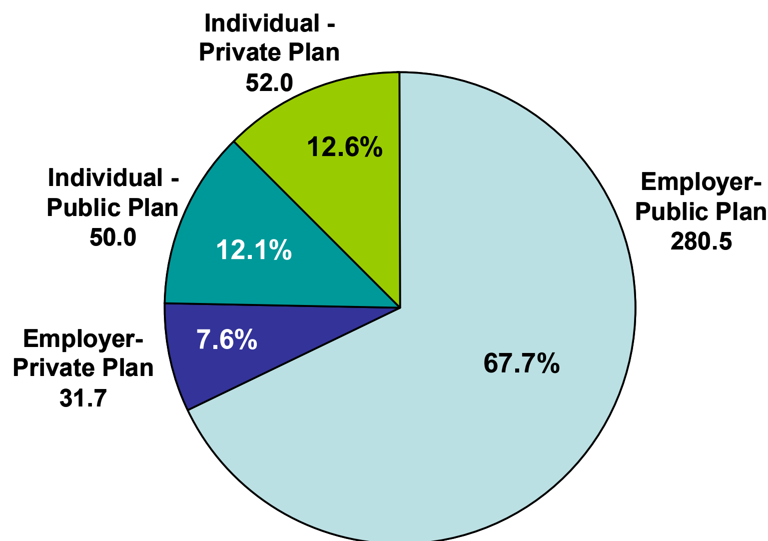
a/ This scenario assumes that the exchange is open to all individuals and employees in 2011.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

In year 3 of the program (2015), individuals and all employers may participate in the exchange and the public plan. If fully implemented in 2011, we estimate that about 330,500 people would become covered under the newly established public plan. Coverage under private insurance would decline by 256,700 people. This is a 52 percent reduction in the number of people with private insurance (currently 489,200 people).

Under current law, there will be about 426,900 people who are covered under an employer plan as workers, dependents or early retirees in 2011. If the act was fully implemented in that year, about 265,400 workers would shift from private employer insurance to another option. However, about 280,500 people would become covered under the public plan with an employer paying a share of the premium. This is a net increase in the number of people with coverage where the employer is paying a portion of the premium of about 15,000 people.

Overall, 414,100 people would obtain coverage through the exchange (***Figure 4***). These include about 312,200 people obtaining coverage with the aid of an employer premium contribution; which includes 280,500 people covered under the public plan and 31,700 taking coverage under a private health plan offered in the exchange. About 102,000 people would obtain coverage as individuals in the exchange, of whom about half would be enrolled in the public plan.

Figure 4
Number of People Covered under the Exchange Assuming Full Implementation in Montana in 2011 (1,000s)[a/]



Number enrolled in Exchange = 414.1

a/ Assumes all firms are eligible to enroll in the exchange.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

In ***Figures 5 and 6***, we present the distribution of Montana enrollees in the public plan across demographic groups. Enrollees are presented by family income, age of the family head and type of enrollment (employer, individual, recipient of subsidies). In addition, we present workers and dependents by firm size and industry. Estimates are provided separately for people with private employer coverage under current law who shift to the public plan.

Figure 5
Number Covered under the Public Plan under the House Bill in Montana in 2011 by Income, Age and Subsidy Status[a/]

	All In Public Plan	Privately Insured Who Move to Public Plan
Family Income		
Less than $10,000	5,600	2,986
$10,000-$19,999	10,203	3,947
$20,000-$29,999	20,428	9,610
$30,000-$39,999	28,654	17,659
$40,000-$49,999	26,605	18,304
$50,000-$74,999	63,812	49,932
$75,000-$99,999	67,447	60,060
$100,000-$149,999	70,340	63,828
$150,000 or more	37,785	33,575
Age		
< 19	79,699	61,078
19-24	24,155	15,629
25-34	58,898	44,460
35-44	52,790	42,155
45-54	60,625	51,086
55-64	51,699	42,579
65 +	3,009	2,915
Receive Subsidy		
No	281,164	242,431
Yes	49,710	17,470
TOTAL	330,874	259,901

a/ Assumes all firms are eligible to enroll in the exchange.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 6
Number of People Enrolled in Public Plan by Industry and Firm Size in Montana in 2011

	All In Public Plan	Privately Insured Who Move to Public Plan
Workers and Dependents		
Firm Size		
Under 10	56,473	34,514
10-24	31,417	21,793
25-99	42,350	34,138
100-499	39,179	31,238
500-999	12,560	10,698
1000-4999	16,290	12,112
5000+	66,170	61,425
Government	57,125	52,630
Industry		
Construction	32,579	21,378
Manufacturing	31,658	27,694
Transportation	16,841	13,709
Wholesale	8,092	7,170
Retail	33,178	25,767
Services	101,207	77,087
Finance	24,569	21,302
Government	57,125	52,630
Other	16,314	11,810

a/ Assumes all firms are eligible to enroll in the exchange.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

D. Detailed Physician Impacts Analysis

We estimated the changes in net-income to Montana's physicians and other health practitioners resulting under the Act. These estimates reflect reductions in uncompensated care as the number of people without health insurance declines. These reductions in uncompensated care represent a net increase in income to providers. We also include increases in revenues for new health services utilization among newly insured people at the provider payment levels used under these programs. We adjusted revenues from private insurers to simulate the effect of shifts in enrollment to the public plan at various provider payment levels for the four scenarios. Finally, we include the effect of an extensive list of reforms in Medicare payments included in the Act, which would generally reduce provider reimbursement (***Figure 7***).

In addition, we estimated increases in practice expense associated with providing services to the newly insured. We assumed that the marginal cost of providing these services is equal to 80 percent of average costs.[2] The resulting data show the net change in physician revenues and net income under each of the public plan scenarios considered in this study (***Figure 7***).

Figure 7
Impact of Public Plan on Physician and Other Practitioner Revenues, Expenses and Net Income under the Act by Public Plan Eligibility Group in Montana in 2011

		Groups Eligible for the Public Plan		
	No Public Plan	Year 1: Individuals and Firms with Fewer than 10 Workers	Year 2: Individuals and Firms with Fewer than 20 Workers	Year 3: Individuals and All Firms
Physician Revenue Effects (millions)				
New Utilization	$66.9	$69.7	$71.1	$71.6
Reduced Uncompensated Care	$0.5	$0.5	$0.6	$0.6
Increased Payments for Primary Care Under Medicaid	$2.5	$2.5	$2.5	$2.5
Reduced Benefits Management Effect	$0.0	$4.4	$7.5	$25.5
Payment Level Adjustment [a/]	-$7.8	-$22.5	-$38.1	-$129.7
Medicare Payment Adjustments [b/]	$3.0	$3.0	$3.0	$3.0
Net Change	$65.1	$57.6	$46.6	-$26.5
Physician Costs for New Health Services Utilization (millions)				
Costs for Newly Insured	$35.0	$38.8	$41.2	$50.9
Changes in Physician Net Income Without SGR Replacement (million)				
Change in Net Income	**$30.0**	**$18.8**	**$5.4**	**-$77.4**
Summary Impacts				
Change in net income per physician in 2010 [c/]	$11,395	$7,122	$2,056	-$29,355
With replacement of SGR (millions)				
Sustainable Growth Rate	$40.8	$40.8	$40.8	$40.8
Change in Net-Income	**$70.8**	**$59.6**	**$46.2**	**-$36.6**
Change in net income per physician in 2010	$26,873	$22,600	$17,534	-$13,877

a/ Reflects changes in payment levels for people moving to the public plan and currently insured people and includes changes resulting from privately insured people who shift to the expanded Medicaid program.

[2] This is the assumption used by the Center for Medicare and Medicaid Services (CMS) in calculating outlier payments.

b/ As discussed above, we assume that the effects of replacing the SGR as proposed in the President's budget are included in the current policy baseline. Includes payment reductions for year 3 of the program (2015) at 2011 health care price levels.
c/ Assumes about 2,640 non-federal physicians in Montana.
Source: The Lewin Group analysis using the Health Benefits Simulation Model (HBSM).

We estimated the incomes of physicians in Montana under current law based upon data obtained from the American Medical Association (AMA). We estimate that average revenues per physician under current law will be $705,526 in 2010. Of this, about 59 percent would be attributed to medical practice costs. Net income per patient care physician (excluding hospital employees) will be $289,900 in that year.[3,4,5]

Figure 7 presents our estimates of the effect the Act would have on income for physicians and other practitioners. Assuming the program is fully implemented in 2011 (i.e., assume that year 3 of the program occurs in 2011), we estimate that physician net-income would fall by $77.4 million, which is a reduction of 10 percent. The loss of net-income under this scenario would average about $29,335 per physician assuming the program is fully implemented in 2011. When the replacement of the SGR is included, the change in net-income under the Act would be a reduction of $36.6 million.

We also present in ***Figure 7*** estimates of the changes in physician income under scenarios where there is no public plan and under scenarios where enrollment is limited to individuals and smaller employers.

E. Detailed Hospital Impacts Analysis

We estimated the impact of the Act on hospital net-income in Montana. We used data primarily from the Medicare Hospital Cost Reports for federal fiscal year 2007. These data provide information on total hospital net patient revenues, other income, total operating expenses and other expenses for each community hospital. The Medicare Hospital Cost Report data also includes information on revenues and expenses related to Medicare patients, uncompensated care expenses and inpatient utilization for Medicare, Medicaid and all other payers. All hospital payments and revenues were controlled to match hospital totals from the National Health Expenditure data by payer category and inflated to 2011. [6,7]

We used these data to estimate the change in hospital revenues resulting from the various health reform options. These reflect reductions in uncompensated care resulting from expanded

---

[3] "Physician Characteristics in the US: 2007 Edition," American Medical Association
[4] "Physician Socioeconomic Statistics: 2000-2002 Edition," American Medical Association
[5] "Cost Survey for Multispecialty Practices: 2006 Report," Medical Group Management Association
[6] Centers for Medicare & Medicaid Services, June 11, 2009 at http://www.cms.hhs.gov/nationalhealthexpenddata/
[7] American Hospital Association, "Trendwatch Chartbook 2009"

health insurance coverage, which represents a net increase in revenues to hospitals. We then estimated increases in revenues for new health services utilization for the newly insured at the provider payment levels used under affected programs including Medicaid, private insurance and self-pay. Finally, we adjusted revenues from private insurers to simulate the effect of shifts in enrollment to the public plan at provider payment levels specified in the ACT (***Figure 8***).

In addition, we estimated increases in operating expense associated with providing services to the newly insured. We assumed that the marginal cost of providing these services is equal to 80 percent of average costs. The resulting data show the change in hospital net income under four public plan design scenarios.

We estimate that total net income for Montana's hospitals will be about $141.5 million in 2011 under current law. This is an average hospital margin of 4.5 percent. If the public plan is open to individuals and all employers using Medicare payment levels, hospital net income would fall by $268.5 million, which is greater than total hospital margin for the year (***Figure 8***). We estimate that hospital total margins would decline to -4.0 percent under this scenario.

Figure 8
Impact of Public Plan on Hospital Revenues and Expenses under the Act by Public Plan Eligibility Group in Montana in 2011

	No Public Plan	Groups Eligible for the Public Plan: Year 1: Individuals and Firms with Fewer than 10 Workers	Year 2: Individuals and Firms with Fewer than 20 Workers	Year 3: Individuals and All Firms
Hospital Revenue Effects (millions)				
New Utilization	$84.7	$87.7	$90.2	$91.7
Reduced Uncompensated Care	$23.1	$23.8	$24.5	$24.8
Reduced Benefits Management Effect	$0.0	$4.6	$6.3	$25.6
Payment Level Adjustment [a/]	-$4.9	-$46.5	-$62.7	-$257.5
Medicare Payment Reductions [b/]	-$59.3	-$59.3	-$59.3	-$59.3
Net Change	$43.6	$10.3	-$1.0	-$174.7
Hospital Costs for New Health Services Utilization (millions)				
Costs for Newly Insured	$67.8	$73.8	$77.2	$93.8
Changes in Hospital Net Income (million)				
Change in Net income [c/]	-$24.2	-$63.5	-$78.2	-$268.5

a/ Reflects changes in payment levels for people moving to the public plan and currently insured people and Includes changes privately insured people who shift to the expanded Medicaid program.
b/ Includes hospital payment reductions for year 3 of the program (2015) at 2011 health care price levels.
c/ Medicaid Disproportionate Share Hospital (DSH) payments will be reduced starting in 2017 by 1.5 billion in 2017, 2.5 billion in 2018 and 6.0 billion in 2019 (national totals).
Source: The Lewin Group analysis using the Health Benefits Simulation Model (HBSM).