

Federal Health Reform – Economic Impact on Alaska *[*With PRELIMINARY Estimates*]*

Prepared for: Alaska Health Care Commission
By: Mark A. Foster, MAFA
October 14, 2010

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Disclosures

- Mark A. Foster, Principal, Mark A. Foster & Associates (MAFA)
 - Business consultant for economically regulated industries: energy, utilities, telecom and health care. Working on health care policy and health economics research with UAA ISER occasionally *since 2005*, “Alaska’s \$5 billion Health Care Industry” (March 2006, with Scott Goldsmith), telemedicine business models (UAA ISER, ANTHC, ASHPIN, Matt Berman), workforce development issues (UAA ISER, ASHPIN), review of State Level Health Care Reform models (UAA ISER), and Medicare Access Issues (Rosyland Frazier & Linda Leask, UAA ISER). Thanks to Fran Ulmer, Steve Colt & Heather Hudson, ISER Directors, for their continued support of public policy research in Alaska.
 - Alaska Power & Telephone, HydroWest International Board of Directors, recently served on ML&P Board of Directors, chair of Finance & Audit Committee
- Caveats
 - **The analysis and opinions presented here have been independently developed and do not necessarily reflect the views of any clients.**
 - These are *preliminary* *reconnaissance-level* estimates based on readily available public data and analysis from the CMS Chief Actuary, American Academy of Actuaries and others that have been proportionally scaled to Alaska and adjusted to reflect an Alaska market outlook.
 - The health reform package involves a large change in health insurance and health care sectors. These preliminary estimates of impacts on Alaska contain *significant uncertainty*. Nonetheless, these estimates should help shed some light on the magnitude and direction of changes that may result from federal reform – *assuming it is fully implemented*.

Overview

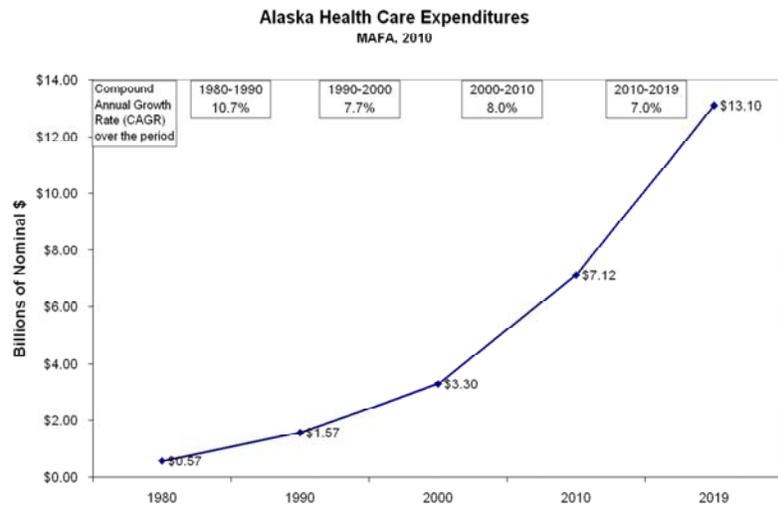
- **Baseline Projections**
 - How much do we spend on health care/health insurance sector in Alaska?
 - Where do Alaskans obtain their health care coverage?
- **How might health coverage and health care costs change under federal health insurance reform?**

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How much do we spend on the Health Care Sector in Alaska?



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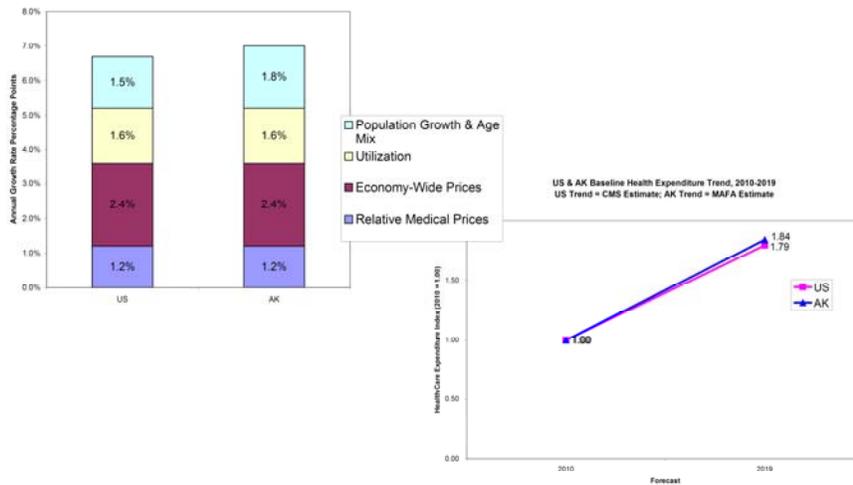
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Note the differences in compound annual growth rates across each of the decades and the projection going forward.

Baseline Spending Projections to 2019 – AK & US

Factors Contributing to Projected Baseline Growth In Health Care Expenditures, 2010-2019



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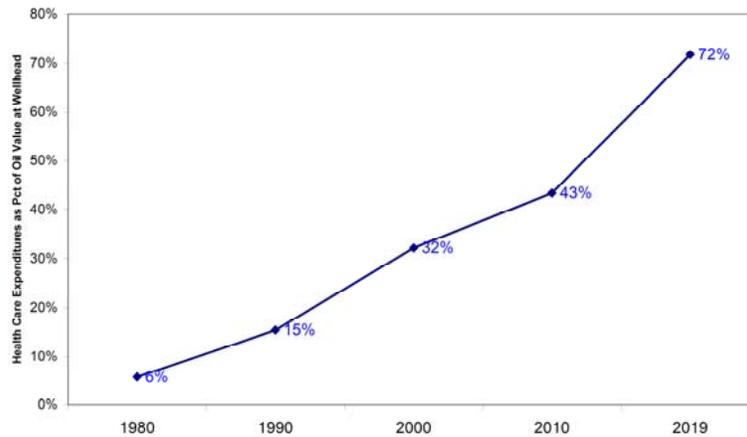
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These preliminary estimates rely upon State of Alaska Department of Labor population projections, including a rapid increase in the proportion of the population 65 and older which tend to drive costs higher faster.

How much do we spend on the Health Care sector in Alaska?

Alaska Health Care Expenditures as Pct of Oil Value at Wellhead
MAFA Analysis, 2010



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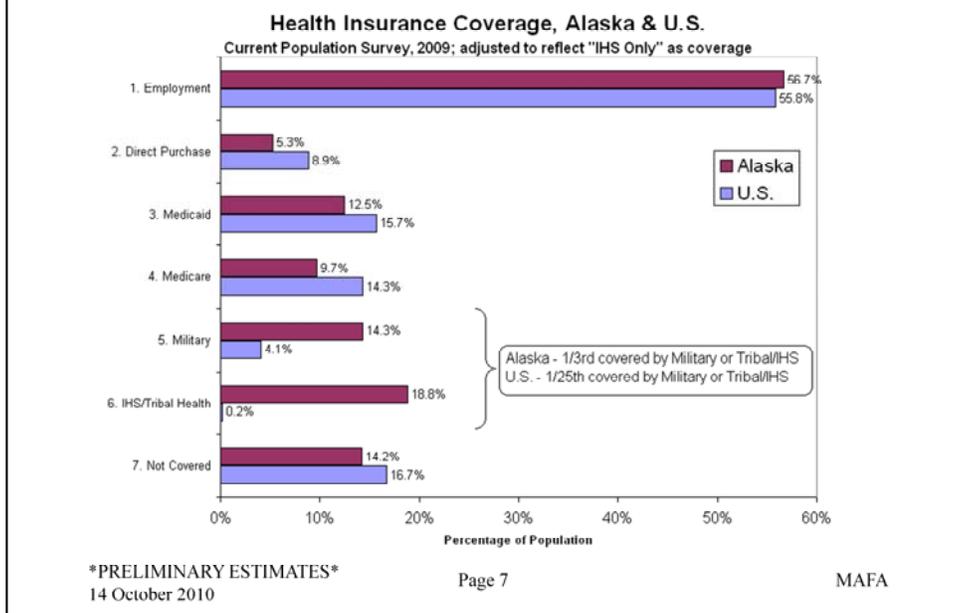
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Another way to look at health care spending is in terms of how quickly it has grown relative to the primary value-add economic driver of the Alaska economy – the well head value of oil.

Sources:

1. Oil: State of Alaska Department of Revenue, Revenue Forecast Update (April 2010), adjusted to reflect CY2010; Historic Values from DNR, DOG Volumes, DOR ANS Wellhead Value
2. Health Care: MAFA Estimate based on CMS NHE Estimates for Alaska (2004), forecast to CY2020 based on Alaska Department of Labor population size and age distribution estimates

Where do Alaskans obtain their coverage?



Note Well: Many Alaskans have multiple health care coverage, hence the total of individual coverage sources adds to more than the population.

The Military and Indian Health Service/Tribal Health systems provide coverage to roughly 1/3 of Alaskans. Combined, these two systems provide 8X more coverage as a proportion of the population in Alaska compared to the U.S. average.

Also note material differences between Alaska and U.S. with respect to:

2. Direct Purchase (3.6 pct points)
3. Medicaid (3.2 pct points)
4. Medicare (4.6 pct points)

How does federal reform address health insurance coverage?

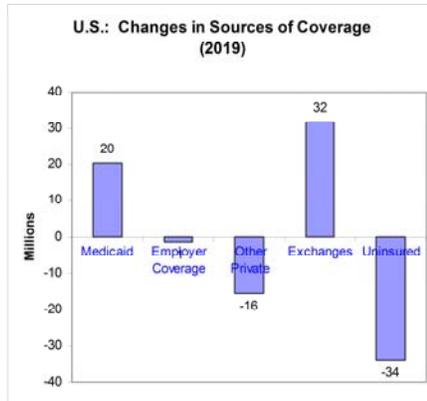
- Medicaid expansion for adults not previously eligible; up to 133% of Federal Poverty Level
- Individual mandate with subsidies & exceptions
- Pay or play mandate for Business >50 employees
- Subsidies for Business <50 employees
- Insurance coverage mandates = young adults up to 26 years on parents plan, “free” preventative services, phase out of benefit limits (exceptions emerging from regulations process), guarantee coverage to all consumers under age 19, mental health coverage

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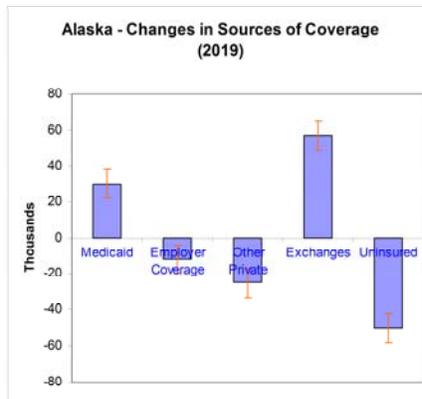
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Health Reform: Projected Changes in Sources of Coverage, 2019 (5 years after individual insurance mandate begins)



Source: CMS Office of the Actuary (22 Apr 2010)



Source: MAFA Preliminary Estimate – CMS Office of the Actuary (22 Apr 2010) with Preliminary Alaska Market Adjustments

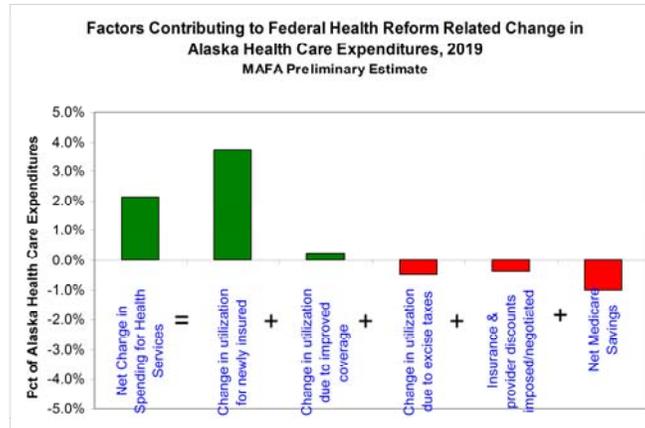
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This is a preliminary estimate of the implications of the Federal Health Care Reform package on health insurance coverage in the U.S. and Alaska **in 2019, a full five years after the individual insurance mandate takes effect**, based on scaling the CMS Office of the Actuary Estimates (22 April 2010) estimate proportions to Alaska with *preliminary adjustments* based on Alaska Market differences from national averages.

Factors Contributing to Change in Spending



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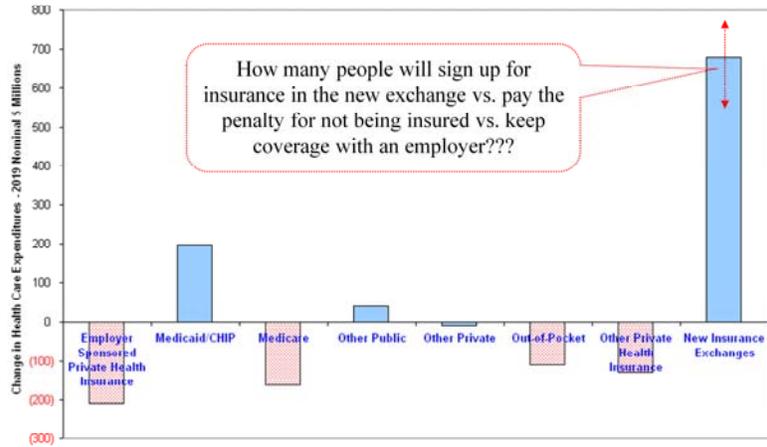
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Here is a summary of the basic factors associated with the Affordable Care Act (ACA) which drive health care expenditures.

Summary of Shifts in Health Expenditures in Alaska, 2019

Impact of Federal Health Reform on Health Care Expenditures - Alaska (2019)
Source: CMS Impact Estimates (April 22, 2010) Applied to Alaska with Local Market Adjustments



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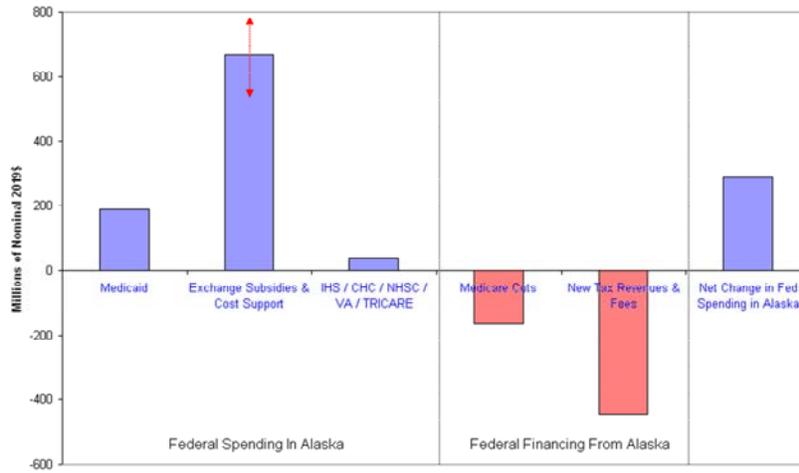
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Change in Federal Spending in & Revenues from Alaska, 2019

Change in Federal Spending in & Revenues from Alaska, 2019

Source: CMS Office of the Actuary (April 22, 2010); JCT (March 20, 2010); with adjustments for Alaska Market



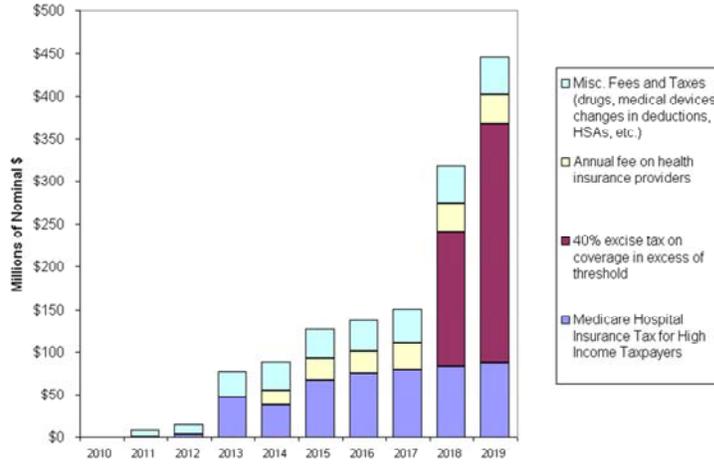
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Alaska Households – Taxes & Fees

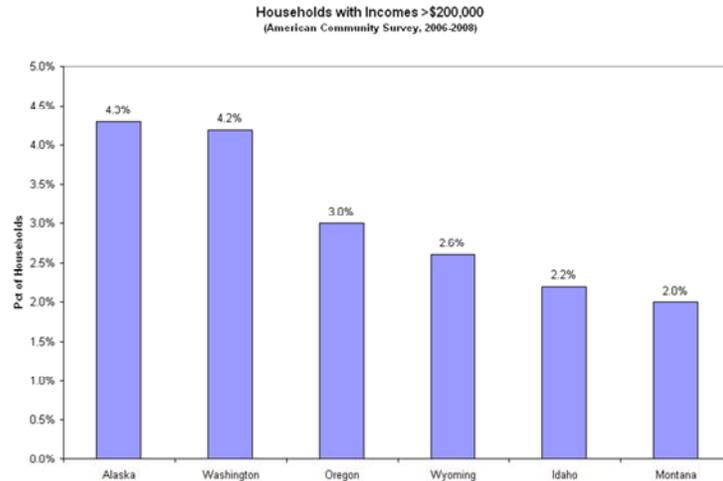
New Taxes & Fees for Alaska Households under Federal Health Reform



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Alaska Households – Taxes & Fees:

Medicare Hospital Tax on income and investment income lands disproportionately on AK & WA due to higher proportion of household incomes > \$200K/year



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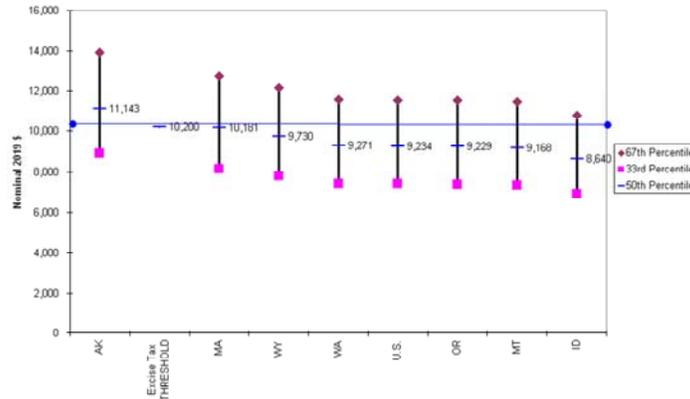
It appears that Alaska has roughly the same proportion of households with “high income” as Washington State (and it turns out the U.S. as a whole) – we use the American Community Survey data from 2006-2008 as a proxy for the proportion of high income households (>\$250,000) in the U.S. and in the Western States that would be subject to the Medicare Hospital Tax.

It appears that several other Western States (OR, WY, ID, MT) have a smaller portion of high income households and their economies can expect a lower *relative* federal Medicare Hospital Tax burden on their economies as a result.

Alaska Household Taxes & Fees:

40% excise tax on health insurance above excise tax thresholds hits Alaskan households disproportionately due to **higher cost of health care and health insurance in AK**

Estimate of Single Premiums in Selected Western States/U.S. in 2019
Source: MEPS, 2008; Projected to 2019



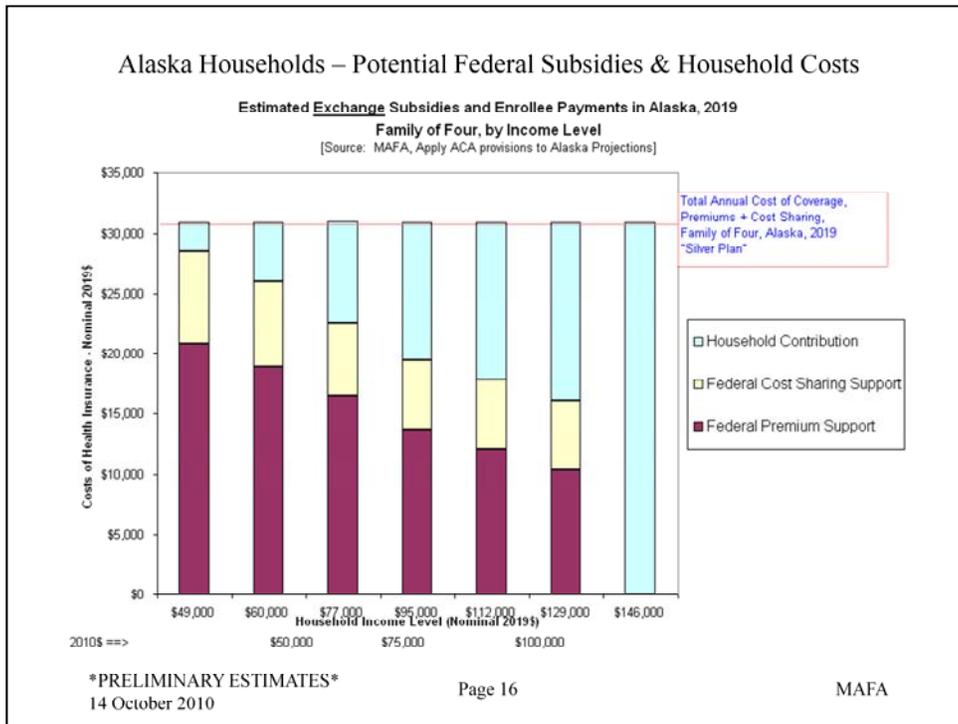
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Based on current projections of cost increases and starting with a higher cost base of Alaska insurance, the 40% excise tax on high cost insurance may have a larger impact on the residents of Alaska compared to other states as a rapidly increasing portion of Alaskan health insurance plans look likely to exceed the excise tax thresholds by 2019.

This projection illuminates current trends. It does not attempt to anticipate potential adjustments in wage/benefit ratios in compensation packages that are likely to occur as employees and employers adjust wages and benefits in light of the new tax on benefits.



The PPACA provides for premium subsidies and cost sharing support for those with incomes <400% of federal poverty guidelines who enroll in health insurance offerings through the new insurance Exchange.

This chart is an estimate of the Exchange subsidies (premium support plus cost sharing support) and enrollee contributions toward health care costs for a family of four in Alaska in 2019 separated into household income levels that correspond to the mid point of the poverty level “bins” established in the PPACA, e.g., 133-150%, 151-200%, 201-250%, 251-300%, 301-350%, 351-400% of FPL.

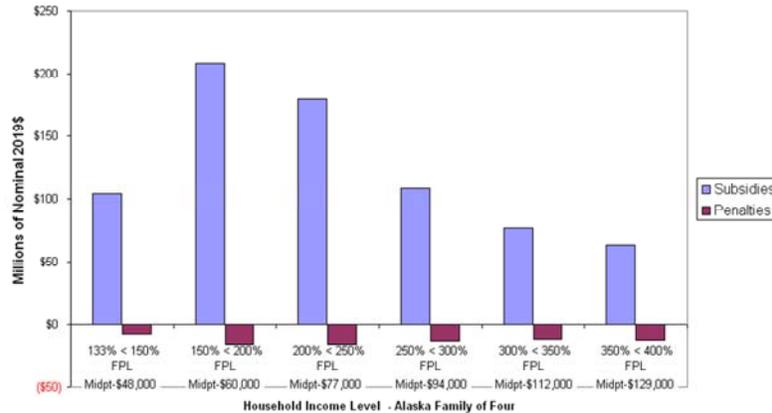
Please note that any household contributions to these insurance costs are made with after tax dollars as compared to health insurance offered by employers that is under the 40% excise tax threshold (\$27,500 for a family plan). You’ll note the estimated cost of health insurance for our “reference plan” for a family of four (“Silver Plan” described in the PPACA) is \$30,900 for premiums **and** cost sharing (deductibles, co-pays).

Also note that the *household contribution* as a percentage of household income is projected to run from 5% for households with incomes 138%-150% of FPL to around 20% for for households between 400%-500% of FPL.

Alaska Households - Aggregate Estimate of Subsidies & Penalties by Income, 2019

Aggregate Household Subsidies (<400% of FPL) & Penalties by Income Levels, AK, 2019

(Estimates assuming 50% sign-up in exchange and 50% either retain or find Employer Sponsored Insurance or pay penalty and remain uninsured)



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The net effect of higher poverty guidelines and a higher cost of care/insurance in Alaska is a relatively high level of premium subsidies and cost sharing support that could potentially flow to Alaskan households eligible for subsidies and cost sharing.

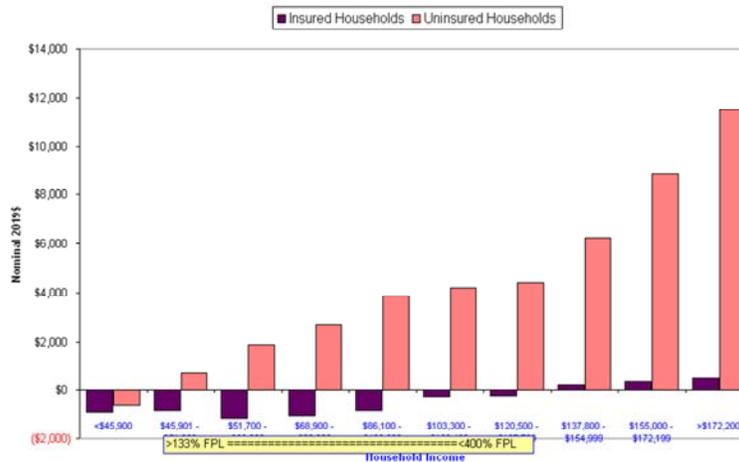
Here, assuming 50% of those eligible enroll in the new Exchange and 50% either retain or find Employer Sponsored Insurance or pay the penalty and remain uninsured, we estimate, based the proportion of the population in each income bin in 2019, the aggregate amount of subsidies and penalties that might be received/paid by Alaskan households.

In addition, American Indians/Alaska Natives (AI/AN) do not have to pay co-pays or other cost sharing if their income does not exceed 300 percent of Federal Poverty Guidelines. The higher proportion of AI/AN in Alaska creates the *potential* for additional federal cost sharing subsidies depending upon whether AI/AN households sign up for insurance under the new Exchange.

Given the relatively generous subsidies and cost support available to individuals in the Exchanges compared to the relatively limited amount of support available to businesses, it would not be surprising to see a number of businesses consider dropping insurance coverage and increasing wages in order to provide a net benefit to their employees and reduce their overall cost of labor at the same time. It is also worth noting that Employer Sponsored Health Benefits under the excise tax thresholds are pre-tax, while purchases of mandated health insurance in the Exchange will use after-tax income, which becomes a consideration in the discussion between employers/employees over potential shifts in wage/benefit policies.

Alaska Households - Change in Spending by Income, 2019

Changes in Avg. Alaskan Household Health Spending Under Reform, 2019



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Please note that this represents the aggregate average of:

Previously non-group insured who shift to the subsidized Exchange

Previously employer-sponsored insured who shift to the subsidized Exchange

Previously employer-sponsored insured who stay with their employer-sponsored coverage

Previously uninsured who shift to the subsidized Exchange

Previously uninsured who remain uninsured and pay a penalty

Previously uninsured who remain uninsured and are exempt from the mandate and associated penalties

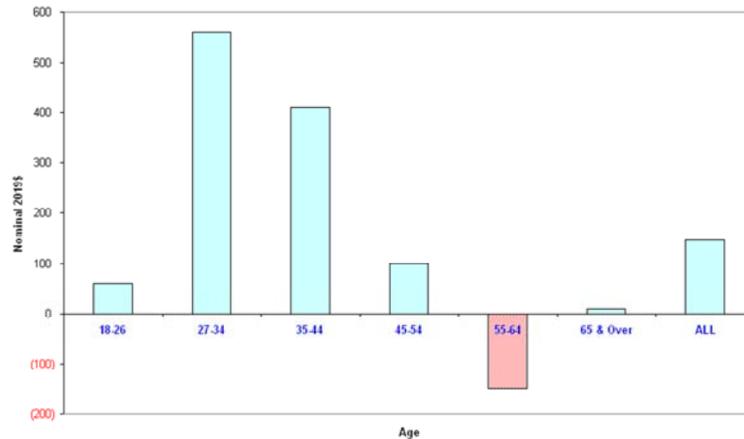
The significant changes *in health spending* by income associated with health reform include:

In aggregate average, households that change from Employer Sponsored Insurance to the Subsidized Exchange and receive a net reduction in expenditures due to generous subsidies relative to previous support for health care from their employer.

Previously uninsured who receive both subsidies and cost support to cover a portion of their total health care bill, but most also come up with additional out of pocket cost support (deductibles, co-pays) beyond what they would have without health insurance.

Alaska Households - Change in Spending by Age of Household Head, 2019

Changes in Average Annual Family Health Spending by Age of Household Head - Alaska
Source: MAF Estimates, June 2010



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The change in the average annual family health spending by age is primarily driven by the change in expenditures by age associated with the new enrollees in the subsidized insurance Exchange.

Some of the new enrollees in the Exchange are coming from the non-group market where premium age bands are typically on the order of 5:1 – which tend to reflect the underlying cost of care across age groups.

Some of the new enrollees in the Exchange are coming from the Employer-Sponsored Insurance market where premiums are typically based on the age distribution of the employer’s pool of covered employees and tend to reflect actuarial age variation on the order of 5:1 or more.

Some of the new enrollees in the Exchange are coming from the ranks of the uninsured, where previous out of pocket expenditures tend to track direct costs which tend to roughly vary more in line with the insurance market.

The PPACA limits premium variation due to age to 3:1, in essence shifting costs to a younger demographic and reducing costs for an older demographic relative to the prior market where prices tended to follow costs more closely.

		Alaska Business – Overview of Key Provisions by Segment		
AVERAGE ANNUAL WAGES/INCOME	>\$200,000 Net Income	<p>Subject to 40% excise tax on coverage amount above \$10,500/\$27,500 thresholds (single/family)</p> <p>Subject to insurance mandate as individual, Subject to new Medicare taxes, Individual premiums may increase as offset to declining deductibles & co-pays decline under new stds</p>		
	>\$50,000	<p>Subject to insurance mandate as individual, Individual premiums increase as deductibles and co-pays decline to new std, Subsidies available for incomes up to \$69,270/\$141,158 (2019\$) (Single/Family of Four)</p>	Exempt from "pay or play" insurance mandate	<p>Subject to "pay or play" insurance mandate Median Coverage Cost Est (2019) = \$10,600/26,700 Penalty for firms where at least one employee receives subsidies in the exchange = \$2,000 per full time employee (first 30 Employees not counted)</p>
	<\$50,000	<p>Subject to insurance mandate as individual, Individual premiums increase as deductibles and co-pays decline to new std Subsidies available from Exchange</p>	<p>Exempt from "pay or play" insurance mandate Phase I (2010-2013) tax credits available ~26 employees Phase II (>2014) tax credits available for two years, <26 employees</p>	<p>Subject to "pay or play" insurance mandate Median Coverage Cost Est (2019) = \$10,600/26,700 Penalty for firms where at least one employee receives subsidies in the exchange = \$2,000 per full time employee (first 30 Employees not counted)</p>
		Self-employed	<50 employees	>50 employees
FIRM SIZE by NUMBER OF EMPLOYEES				
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Note well that self-employed, roughly 10% of employment in Alaska (similar to U.S.) who are currently purchasing insurance in the non-group (“individual”) market will tend to see an increase in premiums associated with changes in coverage requirements and will in essence be making a larger contribution into the health insurance pool in order to support lower income and less healthy individuals.

To the extent that the self-employed make more than \$200,000 single/\$250,000 household, they will also be subject to additional Medicare taxes.

Effect of Health Reform on Premiums for Health Insurance in 2019

Table 1 - Alaska			
Effect of ACA on Average Premiums for Health Insurance in 2019			
	Percentage of Market		
	NonGroup	Small Group	Large Group
Distribution of Nonelderly Population Insured in Respective Markets	12%	12%	76%
Under the ACA			
Differences in Average Premiums Relative to Baseline			
Due to:			
Difference in Amount of Insurance Coverage	+26% to +32%	0% to +4%	0% to +3%
<i>Cap on deductibles; more first \$ coverage; unlimited lifetime claims</i>			
Difference in Price of a Given Amount of Insurance Coverage for a Given Group of Enrollees	0% to -10%	-1% to -4%	negligible
<i>Open exchange competition may lead to lower prices; alternatively more competitive insurance market may have less bargaining leverage vs. local hospitals and physician groups</i>			
Difference in Types of People with Insurance Coverage			
<i>Healthier new pool vs. anti-selection bias</i>	-10% to +5%	-1% to +2%	0% to -3%
Total Difference Before Accounting for Subsidies	+8% to +32%	+2% to -2%	+3% to -3%

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Please note that this analysis lays out the estimated changes in health insurance premiums by type of insurance market **before subsidies are applied**.

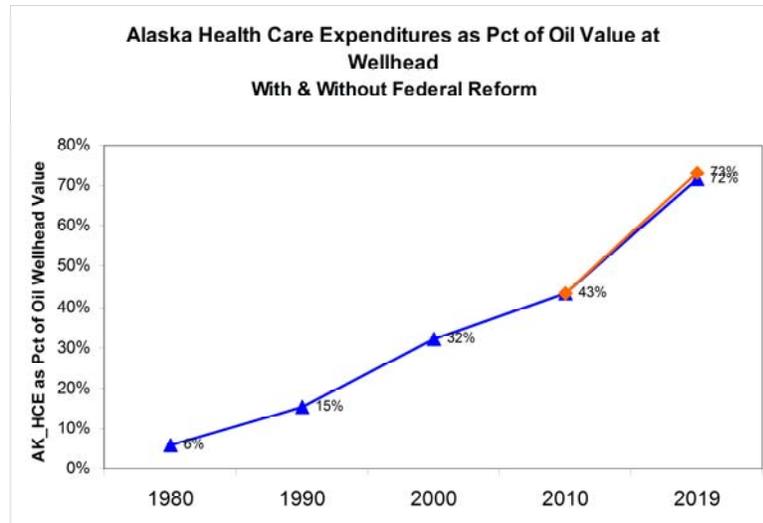
For the net effect of the health insurance cost changes and new subsidies, see

Slide 16 “Alaska Households – Potential Federal Subsidies & Household Costs”

Slide 18 “Alaska Households – Change in Spending by Income”

Slide 19 “Alaska Households – Change in Spending by Age of Household Head”

Alaska Health Care Sector Expenditures, 2019



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Finally, it is worth noting that the incremental impact of health care reform might be on the order of \$250 million in net new health care expenditures on \$18 billion of Oil Wellhead Value in 2019 in Alaska; which amounts to a 1.4% increase.

While the increase associated with the ACA may be a relatively small increase in overall health expenditures, it can also be seen by those who are concerned with rapidly escalating cost growth as a lost opportunity.

Current and past Congressional Budget Office (CBO) directors have become increasingly concerned that rapidly escalating health care costs, especially for federal programs [Medicaid and Medicare], are simply not sustainable. See also Joe Newhouse, Implied Federal Tax Rates required to sustain Medicare on its current trajectory, figure 4, “Assessing Health Reform’s Impact on Four Key Groups of Americans”, Health Affairs, September 2010.

Large uncertainties remain.

Will the Medicare reductions for hospitals, nursing homes and home health to capture “productivity” be sustainable or will additional expenditures be required to sustain Medicare?

Will Medicare reductions be made in physician payments similar to the “productivity” adjustments slated for hospitals, nursing homes and home health?

If the slated Medicare productivity savings are achieved, will they be an artifact of “cost-shifting” (accepting lower margins for Medicare while increasing margins for other payers) or will the productivity savings reflect more efficient operations throughout the hospital, nursing home and home health enterprise and be shared by all health insurance payers?

Will top down global budgeting controls help bend the cost curve at the same time there is an aggregate reduction in out-of-pocket spending by individuals as costs are shifted to others, especially federal subsidy and cost support programs?