



NATIONAL HEALTH CARE REFORM: The Impact on Tennessee

Many Tennesseans will have greater access to health care; but for others it will be worse. A big question remains for the state: How to increase the supply of primary care?

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TABLE OF CONTENTS

Executive Summary.....	2
Part 1: Changes in Access to Services.....	4
Number of people impacted nationally	
Table 1. National enrollment impact of new law in 2014	
Number of people impacted in Tennessee	
Figure 1. 2009 Distribution of income by state	
Number of Tennesseans eligible for the Medicaid expansion	
Table 2. Tennesseans eligible for Medicaid expansion by prior coverage, using 2009 income statistics	
Number of Tennesseans eligible for the premium tax credit	
Table 3. Tennesseans eligible for premium subsidies by prior coverage, using 2009 income statistics	
Table 4. Estimate of exchange migration	
Table 5. The Tennessee health insurance market in 2009 and 2014	
PPACA and primary care capacity in Tennessee	
Approaches to increasing primary care capacity	
Part 2: Shift from Employer-Provided Insurance	13
The health exchanges and premium subsidies	
Table 6. IRS estimates	
How the employer penalty for dropping coverage actually becomes an incentive to drop coverage	
Figure 2. Total number of employees and dependents using public assistance in Massachusetts after reform	
Premium impact of PPACA in Tennessee	
How the premium impact will affect real people	
The individual mandate	
Part 3: Increase in State Funding Requirements.....	20
Nationwide spending related to PPACA	
The Medicaid expansion in Tennessee	
Figure 3. Estimate of spending on Tennessee Medicaid	
Conclusions	22
What PPACA will do on the national front unless materially altered	
National winners and losers as a consequence of this shift	
Tennessee winners and losers as a consequence of this shift	
Looking Ahead in Tennessee.....	24
Primary care capacity	
Funding	
Administration	
Appendix.....	25
About the Authors.....	35



EXECUTIVE SUMMARY

The passage of national health care reform has sweeping implications for the delivery and financing of health care. Millions of currently uninsured Americans will be covered under the new law. New requirements include everything from the extension of children's coverage on their parents' policies to age 26, to a 10% tax on tanning salons.

While the changes are national, two extremely significant elements of the new law also have specific impacts on Tennessee that will require thought and action from state leaders, ranging from legislators and the governor, to those in charge of providing care, to those who run the state's medical schools. Those two elements are the expansion of Medicaid, known as TennCare in Tennessee, and the creation of a subsidized market for commercial health insurance, which is called the "exchange." Taken together, these two elements represent the largest expansion of entitlement programs since Medicare was enacted in 1965.

The purpose of this white paper is to explore how the expansion of Medicaid and the creation of the exchange will impact Tennessee and to help frame the issues that will need to be addressed. Of necessity, a substantial amount of background about the national program must be included to understand the impact on Tennessee, but this paper does not attempt to be a comprehensive look at all aspects of the new health care law.

In brief, here is the likely impact on Tennessee:

Changes in access to services

Generally speaking, *many Tennesseans who were previously uninsured will have better access to health care.* That will in turn create a stronger demand for health care services. Since the number of providers will not increase in the short run, there will be a strain on the system's ability to supply services. That may mean, generally speaking, *worse access to services for those who are currently insured,* unless they are wealthy enough to afford "concierge" medicine. *Tennessee's access problems likely will be somewhat worse than those of the nation at large.*

Shift from employer-provided insurance

The number of state residents obtaining health insurance through their employers may decrease significantly as companies attracted by the true incentives in the new health care law drop coverage and allow their employees to obtain coverage through the exchange. This could result in a modest initial financial gain for businesses in Tennessee.

Some increase in state funding requirements

As more previously uninsured Tennesseans (and others) become eligible for Medicaid, the amount of required state funding will increase. This should amount to approximately 1% per year of the portion of the state's budget that is funded by state taxes (as opposed to federal funds.)

The questions that result for Tennessee's leaders are numerous:

- Are there ways to increase the number of primary medical providers in the state, especially physicians?
- Are there different ways to provide health care, such as making more extensive use of nurse practitioners, that will effectively increase the supply of services?
- Will young people in sufficient numbers pursue careers in patient care when the new law appears to encourage a system of price controls?
- Will business leaders feel a responsibility to continue providing health insurance for their employees when they could reap economic benefit by dropping coverage and allowing employees to purchase coverage – in some cases subsidized by the government – through the exchange?
- Will that sense of responsibility persist if competitors choose to drop coverage?
- How will the state meet its financial obligations to support an expansion of TennCare (Medicaid)?

The challenge is clearly substantial. The state has already made progress in addressing some of these questions. But much more work remains to be done, and we hope that this white paper will provide a useful framework for tackling it.

PART 1: CHANGES IN ACCESS TO SERVICES

Number of people impacted nationally

There are two principal ways in which health care insurance coverage is expanded under the new law, formally known as the Patient Protection and Affordable Care Act of 2010 or PPACA:

1. An expansion of Medicaid, making it available to all those with an income of 133% or less of the federal poverty level. Eligibility was previously limited to certain classes of individuals, such as low-income pregnant women, children from low-income families and others.¹
2. Premium subsidies for the purchase of private health insurance, which will take place at statewide health insurance exchanges.

Those whose income is up to 400% of the federal poverty level are eligible for a premium subsidy if their premium exceeds the income cap. The cap is the portion of a person's income that the law deems as the most that someone should have to pay for health insurance (see Appendix). There are other ways that one might become eligible for insurance coverage through the health insurance exchange besides income:

- If an employer relinquishes its health plan's "grandfather"² status.
- By working for a small employer (fewer than 50 employees).
- By having individual coverage.
- At the employee's choice.

Both the Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS) have estimated the new law's impact on insurance enrollment. The Congressional Budget Office estimates that the number of Americans without health insurance will be reduced by 19 million. The Centers for Medicare and Medicaid Services estimates that number at 26.2 million.

Table 1. National enrollment impact of new law in 2014

Health Insurance Segment	CMS (millions)	CBO (millions) Non-elderly	Variance (CMS-CBO)
Medicaid & Children's Health Insurance Program	+23.0	+10.0	+13.0
Employer	+2.0	+4.0	-2.0
Individual & other private insurance	-13.2	-2.0	-11.2
Exchanges	+16.9	+8.0	+8.9
Uninsured	-26.2	-19.0	-7.2

CMS states that the numbers it uses in the individual and other private insurance category are based on private individual coverage and Medicare supplemental coverage for 2013, but only include private Medicare supplemental coverage in 2014, when the new law takes effect. That suggests that in 2014 and beyond CMS has assumed 100% of those currently covered by private individual policies will

¹ <http://www.tn.gov/tenncare/mem-categories.html>

² Grandfathered plan refers to a health plan or health insurance coverage in which an individual is enrolled on the date of enactment (March 23, 2010). Grandfathered plans (1) include plans that are renewed after this date; (2) allow for enrollment of family members, if such enrollment is permitted under the terms of the plan in effect on the date of enactment, and (3) allow for enrollment of new employees (and their families).



elect to be covered through the exchange or will meet the income requirements for either Medicaid enrollment or premium subsidy through an exchange.

The CBO, in its estimate, indicates that effects on the individual and other private insurance category of the new law are “almost entirely” on individual coverage; however the projected magnitude of the effect is much smaller. That is, the two analyses generally agree on where the primary effects of the new law are (the individual market), but not on the size of the effects.

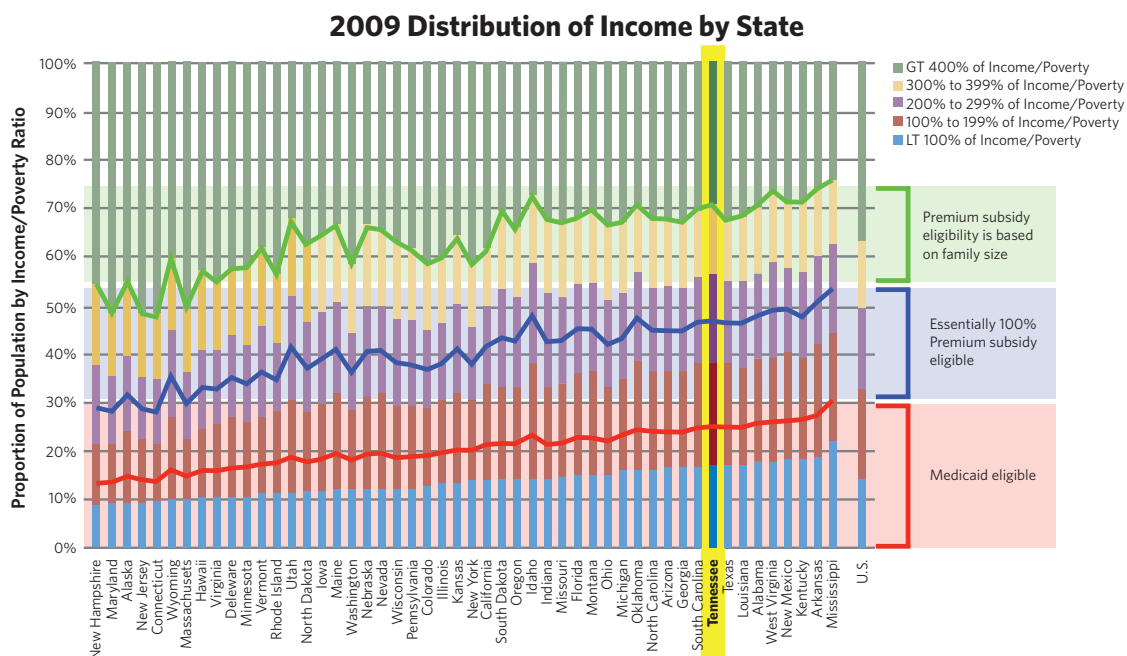
Number of people impacted in Tennessee

The impact of PPACA state by state varies by level of economic well-being. As such, Tennessee falls towards the bottom of the rankings.

Figure 1 below ranks states by income for 2009 and shows a variety of factors related to PPACA:

- The bright red line at the 138% income/poverty ratio shows the PPACA Medicaid income eligibility criterion. Medicaid eligibility under PPACA ranges from 13.3% of the population in New Hampshire to 30.6% of the population in Mississippi. 25.1% of the 2009 population is eligible in Tennessee for Medicaid under the PPACA criterion.
- The blue line represents an income/poverty ratio of 250% under which 100% of 2009 Tennesseans would be eligible for premium tax credits through the exchange and PPACA, given the average private health insurance premium and the range of premium income caps. This is important because this is the level at which people are almost certainly better off in the exchange than with a typical employee health plan (48% of Tennesseans).
- The green line at an income of 400% of poverty shows the maximum income level at which premium subsidies could apply. Applied to all states this range provides an approximation of how premium subsidy eligibility varies by state. In Tennessee, Medicaid and premium subsidy eligibility taken together cover about 69% of the population. In practice, eligibility at the higher income/poverty ratios qualifies those in smaller families.

Figure 1. 2009 Distribution of Income by State



Source: Census Bureau; Eligibility estimates by authors

The graph makes other important points:

1. The portion of the population with high incomes (greater than 400% of poverty, the teal portion of the stacked bar) ranges from about 50% in wealthy states such as Massachusetts and Maryland to 30% in Tennessee and Mississippi.
2. The portion of population with low incomes (less than 100% of poverty, the dark blue portion of the stacked bar) ranges from less than 10% in wealthy states to twice that in poor states.
3. The implication of these two points is that it is much more affordable to expand health care coverage and welfare in high income states with a high-to-low income ratio of 5 because their need is not as great and their resources are relatively large. It is far less affordable to expand coverage in low-income states where the high-to-low income ratio is 1.5 and their resources are not great but their need is.

Number of Tennesseans eligible for the Medicaid expansion

An estimated 609,567 Tennesseans would be eligible for Medicaid expansion coverage under PPACA as shown in Table 2.

Table 2. Tennesseans eligible for Medicaid expansion by prior coverage, using 2009 income statistics

Health Insurance Coverage Segment	Non-Elderly Income/Poverty <133% ³
Employer Provided	184,363
Direct Purchase	47,575
Not Covered	377,629
Total	609,567

Additional considerations:

- 1) CMS estimates the first year (2014) Medicaid expansion population at 23 million, while CBO estimates 10 million.
- 2) CBO estimates that Medicaid coverage increases to 16 million by 2019, a further increase of 6 million over that in 2014, the first expansion year, while CMS estimates that Medicaid coverage will remain flat following 2014 through 2019.

(The geographic distribution of residents with Medicaid expansion eligibility are shown in the Appendix maps and tables by coverage type and generally follows county population size.)

³ This income/poverty ratio criterion is adjusted so that it is in effect 138% of FPL due to the “disregard” that is used by states for Medicaid/CHIP enrollment eligibility. “Disregards” have been used in children’s Medicaid and SCHIP. States may disregard (not count) a portion of earnings from a working family’s income to account for resources that are needed to cover work-related expenses and not available to cover other costs, such as the cost of purchasing health coverage. Typical disregards include child care and child support. Donna Cohen Ross, Aleya Horn, Robin Rudowitz and Caryn Marks. Determining Income Eligibility in Children’s Health Coverage Programs: How States Use Disregards in Children’s Medicaid and SCHIP. Kaiser Commission on the Uninsured, Policy Brief, May 2008. Available at: <http://www.kff.org/medicaid/upload/7776.pdf>

Number of Tennesseans eligible for the premium tax credit

An estimated 1,517,692 Tennesseans will qualify for a premium subsidy because of their income and because their health insurance premium is in excess of the income cap. (See Appendix.)

Table 3. Tennesseans eligible for premium subsidies by prior coverage, using 2009 income statistics

Health Insurance Coverage Segment	Non-Elderly Income/Poverty <133% FPL to <400% FPL
Employer Provided	1,081,838
Direct Purchase	122,644
Not Covered	314,010
Total	1,517,692

Some portion of those from the employer provided category may not qualify for premium subsidy based on the premium income cap. All people under 200% of the federal poverty limit are likely to qualify based on the premium income cap, given the average single coverage Tennessee premium in 2009 of \$4,549,⁴ and average family coverage premium of \$12,134, although the premium price trend through 2013 will have an obvious potential to change the picture.

In general, the geographic distribution of Tennesseans with premium tax credit eligibility follows county population size. The largest number of residents with employer provided insurance who are eligible for the premium tax credit are from Shelby County with 152,626. The next largest counties are Davidson at 110,293, Knox at 85,840 and Hamilton at 63,168. The smallest counties are Pickett at 678, Van Buren at 767 and Moore at 876. The largest number of residents who directly purchase insurance and are eligible for the premium tax credit are from Shelby County with 23,159. The next largest counties are Davidson, 20,667, Knox at 13,627 and Hamilton at 8,788. The smallest counties are Pickett at 4, Van Buren at 4 and Moore at 5.

The geographic distribution of residents with premium tax credit eligibility is shown in the Appendix maps and tables by coverage type.

⁴ Medical Expenditure Panel Survey. Agency for Health care Research and Quality.

An estimate of those who will migrate to exchange-based coverage is shown in Table 4 below by their previous coverage. Note this table includes employees and dependents.

Table 4. Estimate of exchange migration

Health Insurance Coverage Segment	2014 Population, Includes Dependents	2019 Population, Includes Dependents
Employer Provided	413,825	928,088
Direct Purchase	328,837	341,077
Not Covered	323,792	334,389
Total	1,066,454	1,603,554

The basis of these estimates is the Massachusetts experience for organizations with 50 employees or more and the standardized adoption curve for small employers, that is, those with fewer than 50 employees. However, note that many estimates are much higher based on the incentives to drop coverage inherent within PPACA. Even Joel Ario, head of the health insurance exchange office in the Department of Health and Human Services, said, “If the exchanges work pretty well, then the employer can say ‘This is a great thing. I can now dump my people into the exchange and it would be good for them, good for me.’”

The Tennessee health insurance market, like the national market, is expected to change substantially from 2009 to 2014. Table 5 below is our, the authors’, forecast of how the Tennessee market will likely change by 2014 due to PPACA.

Table 5. The Tennessee health insurance market in 2009 and 2014

Segment		2009 Actual, Includes Dependents	2014 Under PPACA, Includes Dependents
Single Coverages	Population	6,253,000	6,448,000
	Not Covered	963,000	280,000
	Covered by Government or Private Health Insurance	5,290,000	6,168,000
	Private Health Insurance	3,744,000	2,937,000
	Employment Based	3,209,000	2,692,000
	Direct Purchase ¹	555,000	244,300
	Non-elderly Direct Purchase ²	318,000	0
	Elderly Direct Purchase ³	237,000	244,300
	Medicaid	1,021,000	1,681,000
	Medicare	1,029,000	1,061,000
	Military ⁴	448,000	462,000
	Exchange	0	1,066,000

Notes:

- 1) Private coverage purchased directly by consumer.
- 2) Non-elderly direct purchase is likely to represent individual coverage.
- 3) Elderly direct purchase coverage is likely to represent Medicare Supplemental coverage, excludes Medicare Advantage.
- 4) Military health care includes Tricare and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), as well as care provided by the Health and Medical Program of the Department of Veterans Affairs and care provided by the Department of Veterans Affairs and the military.

PPACA and primary care capacity in Tennessee

As noted above, PPACA will expand insurance coverage to approximately 680,000 Tennesseans who are not currently covered. The biggest part of this expansion will occur through Medicaid.

It is generally agreed that those newly insured people will consume more health care services than they have been.

If capacity of the system does not expand, this obviously will create a mismatch between supply and demand. In a free market that would result in an increase in price and a new equilibrium. However, Medicaid fees are not free to rise – they are set on a state-by-state basis, and are not generally responsive to market forces. In Tennessee, primary care physician fees for Medicaid average about 80% of Medicare, which in turn is 20-30% lower than the commercial market. (See Appendix, page 31, for Medicaid/Medicare ratio of payment for each state.)

There is a provision in the new law calling for Medicaid fees for some aspects of service by primary care physicians to rise to the level of Medicare in 2012 and 2013 (though not beyond). There is also a 10% additional reimbursement for primary care for Medicare patients for 2011 to 2015.

However, nothing in the law specifically addresses the supply of primary care physicians or the potential for demand to exceed supply. The Association of American Medical Colleges has estimated that nationally there was a shortage of 9,000 primary care physicians in 2010 and forecast it would increase to 29,800 by 2015.⁵

With a mismatch of supply and demand, a price point that is fixed below market and no incentive for supply to increase, the access for those who previously had coverage will necessarily decrease.

In the face of an existing primary care practitioner shortage, exerting price controls and even more regulation over an even larger portion of the population via Medicaid expansion is likely to reduce further the numbers of medical students that might enter primary care. It is also likely to reduce the proportion of a primary care physician's practice that she/he will voluntarily allocate to Medicaid patients.

Cyril Chang and David Mirvis of the Methodist Le Bonheur Center for Health Care Economics at the University of Memphis have examined the likely impact on Shelby County, Tennessee, and found that, "Expanding insurance coverage will increase ambulatory care visits by a projected 145,000 visits per year and will require additional primary care providers at a time when fewer new physicians are choosing careers in primary care."⁶

In Tennessee, we had 6,115 primary care physicians as of December 31, 2008.⁷ That equates to 99 primary care physicians per 100,000 population, compared to a national average of 100. Tennessee ranks 22nd among all states.

⁵ Physician Shortages to Worsen Without Increases in Residency Training. Association of American Medical Colleges. Available at: https://www.aamc.org/download/150584/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf

⁶ Chang, Cyril and Mirvis, David. Guest Column: Health care act has benefits, with caveats. The Commercial Appeal, Feb 3, 2011. Available at: <http://www.commercialappeal.com/news/2011/feb/03/guest-column-health-care-act-has-benefits-with>

⁷ Morgan and Morgan, Health care State Rankings 2010, p422-3.

In a study published in the *New England Journal of Medicine* on February 10, 2011, Leighton Ku and associates developed what they call an “Access-Challenge Index” that essentially compares the impact of Medicaid expansion to primary care capacity. With a score of 100 defined as the mean, Tennessee has a higher than average challenge (i.e., mismatch of supply and demand) of 112.1. Tennessee ranks 20th among the states on the index.

Oklahoma is judged to have the greatest mismatch with a score of 212.6 and Massachusetts the least at 15.2. The study’s authors also observe, “Newly insured populations will demand more primary care services. If the new demand exceeds the supply of care, the result could be increased waiting times and access barriers. This pressure on services could affect not only Medicaid patients, but also privately insured and Medicare patients.”

Another related issue is the compensation of physicians. “From the physician point of view, the key issue is for Medicaid rates to be competitive....”⁸ As mentioned above, in 2013 and 2014, PPACA mandates that Medicaid rates at least match Medicare. Additionally, as mentioned, there is a provision that essentially raises Medicare rates by 10%. It is hoped that this will make it more attractive for graduating medical students to enter primary care.

Most people are aware that primary care physicians earn less money than specialists.⁹ The present value of career wealth for a cardiologist is \$5,171,407; for a primary care physician \$2,475,838. Increasing the income of primary care physicians by 10% for their entire career would make the present value of career wealth \$2,906,517, not exactly closing the gap. It is highly unlikely that a “boost” of the magnitude contemplated in the law (10% in evaluation and management reimbursements for 4 years) will have a significant impact on the supply of primary care physicians.

Approaches to increasing primary care capacity

Dr. Fred Ralston, president of the American College of Physicians and a primary care internist in private practice in Tennessee, sees the Patient-Centered Medical Home (PCMH) model and its team approach as an avenue to increase capacity.

In an interview with the BlueCross BlueShield of Tennessee Health Institute, Ralston said that PCMH is “concierge medicine for everyone.” Patient-Centered Medical Homes are primary care practices, consisting of primary care physicians and nurse practitioners, that either provide for or coordinate all care that its patients need. While some existing primary care practices do a good job of coordinating care, PCMHs are intended to improve performance with a greater emphasis on teamwork.

Ralston further stated that PPACA will of necessity advance the use of a continuum of primary care practitioners, including nurse practitioners, family practitioners, pediatricians and internists. He believes that the present system is at or near capacity and that structural changes will be needed as well as significantly increased numbers of primary care physicians. In Tennessee in particular, he stated that any internal medicine practice that has existing capacity could easily fill that capacity with commercial and Medicare patients. Although he believes strongly that physicians have an ethical responsibility to

⁸ Private communication, Robert Doherty, Sr. V.P. American College of Physicians.

⁹ *Health Affairs*, 29, no.5 (2010):933-940.

treat Medicaid patients, he poses the question, “If you go out of business because the economic reality doesn’t support the moral position, is that, in and of itself, an ethical breach?”

Dr. Paul Stanton, by training a vascular surgeon, has been president of East Tennessee State University and its Medical School and residency programs for 15 years and also serves on the Board of Directors for BlueCross BlueShield of Tennessee. He views the changes from PPACA with cautious optimism. He observes that 80% of the patients served by ETSU’s OB-GYN program are TennCare patients, and the addition of new people to the rolls of TennCare will probably have a beneficial effect on the economics of that practice, at least to the extent that the newly enrolled come from the ranks of the uninsured.

Dr. Stanton sees the need for more primary care physicians and nurse practitioners to accommodate the increased demand, but he believes that between the medical schools and Federally Qualified Health Centers (FQHCs) there is the capacity to meet the challenge, with one important condition: “They can be accommodated if there is no shrinkage of money.”

Federally Qualified Health Centers are clinics that see all patients, regardless of income or insurance coverage and in turn receive government funds.

One of the greatest challenges that medical school deans face is the year-to-year uncertainty of funding for TennCare. The nature of medical education, and certainly graduate medical education, is that it must be budgeted for quite some time in advance. The making of a doctor is a 7-12 year process and does not easily lend itself to the vagaries of annual fluctuations in financial support.

Dr. Chris Smith, Associate Professor and Coordinator of the Family Nurse Practitioner Program at the University of Tennessee at Chattanooga, sees this as an exciting time for nurse practitioners. Applications for the UTC nurse practitioner program have doubled, she says. Unfortunately, UTC does not have enough faculty members to accept all the qualified applicants. Like Dr. Ralston, she sees great potential in the PCMH concept. Also like Dr. Ralston, she says that all her graduates are fully employed and have little, if any, excess capacity. On a positive note, she states that, “Tennessee is very welcoming to nurse practitioners,” a change she has noted over the last 15 years. Only about 25% of her graduates go on to work with specialist physicians; the remainder choose primary care.

Dr. Wright Pinson, Chief Executive Officer of Vanderbilt Hospitals and Clinics, sees a strong role for Accountable Care Organizations (ACOs) which, broadly speaking, are usually hospital-owned or contracted providers that provide or arrange for all of a patient’s care. They also will usually assume at least partial, if not entire, financial risk for the care provided.

Pinson is concerned about decreasing levels of compensation, both from reduced fees brought about as described earlier, and from increasing levels of bad debt. Pinson and his team are particularly concerned about the “bronze” level plan that will be offered on the exchange, since that plan has a 60% actuarial value. What that means is that the health plan will cover 60% of the average person’s medical costs. That leaves a substantial portion of the costs to be covered by the patient. In many cases patients in lower income brackets will not be willing or able to pay.

David Posch, Chief Executive Officer of The Vanderbilt Clinic, agrees that more primary care physicians will be needed. He notes that Vanderbilt is also examining what role specialists may play in primary care, especially as a member of a team treating patients with chronic illness. He cited the Mayo Clinic, where virtually every patient sees a team comprised of nurses, primary care physicians and specialists. He also pointed out that for certain illnesses such as renal failure and cancer, the nephrologist or oncologist actually serves as the primary care physician even today. In any case, he also believes that meeting future needs of our population will involve not only additional primary care physicians, but also structural change in the way medicine is practiced.

While PPACA may greatly enhance access for those newly insured, (assuming the fees are high enough to encourage physicians to see Medicaid patients) it may have the opposite effect upon those who currently have coverage. Alternatively, if private physicians do not choose to accept new Medicaid patients, the patients will be seen in Federally Qualified Health Centers (FQHCs) or other public venues such as emergency departments of hospitals. Whether this will result in a *de facto* two-tier system of medicine, such as is common in Europe, remains to be seen.

Americans are not patient; the wealthier among us even less so. We (the authors) believe that diminishing access for currently insured patients will lead to the rapid expansion of a “luxury medicine” market. This market will be comprised of people who are willing to pay to go to the front of the line. Just like buying good seats at the opera, or flying first class, people with disposable income will be willing to pay to get faster service. There is already such a movement afoot today called “concierge medicine.”

PART 2: SHIFT FROM EMPLOYER-PROVIDED INSURANCE

The health exchanges and premium subsidies

The number of people who take advantage of premium subsidies for insurance bought on the exchange will obviously have an impact on the overall cost of the new law. It will also impact the number of people covered by employer-based plans, since workers at certain income levels will be eligible for premium assistance if they move to an exchange-based plan.



An analysis done for Families USA¹⁰ by the Lewin Group estimates that 28,636,200 people will be eligible for premium assistance nationally in 2014, and 664,100 people will be eligible in Tennessee. The assistance will come via the new premium tax credit.

Eligibility estimates are based on the number of workers who would have to pay more than a specified share of their household income for employer-based coverage, given that their household income is less than 400% of the income/poverty ratio.

For details on how this would break down, see the Appendix, page 27.

The number of people moving to the exchange obviously will also be affected by the number of employers who choose to stop providing health insurance. One indicator of the number of affected employees is a projection by the Internal Revenue Service¹¹ of the percentage of employees currently in plans where employers will drop their grandfather status in the years leading up to 2014.

Table 6. IRS estimates

Estimates of the Cumulative percentage of Employees in Plans Relinquishing Their Grandfathered Status, 2011-2013			
Assumption	2011	2012	2013
Upper Range Assumption			
Small Employers*	20%	36%	49%
Large Employers*	13%	24%	34%
Total	15%	28%	39%
Mid-Range Assumption			
Small Employers	30%	51%	66%
Large Employers	18%	33%	45%
Total	22%	38%	51%
Lower Range Assumption			
Small Employers	42%	66%	80%
Large Employers	29%	50%	64%
Total	33%	55%	69%

* Small employers are defined by the IRS in this analysis as those with fewer than 100 employees, large employers as those with more than 100 employees.

¹⁰ Lower Taxes, Lower Premiums: The New Health Insurance Tax Credit. Families USA. September 2010.

¹¹ Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act.

AGENCIES: DEPARTMENT OF LABOR, Employee Benefits Security Administration
29 CFR Part 2590, RIN 1210-AB42; DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Consumer Information and Insurance Oversight, OCHIO-9991-IFC, 45 CFR Part 147
RIN XXXX-XXXX.

Those employers who choose to relinquish their plan's grandfather status may do so for a variety of reasons, most commonly, a desire to lower their costs or avoid additional expense. For example, the new law includes mandatory benefits which are in excess of those currently provided by many employers. That will make health insurance more expensive for employers to provide.

But the main issue is that PPACA provides what is, in effect, an incentive for employers to drop health care coverage. The incentive is the penalty imposed when an employer drops the coverage. This seeming paradox is described in the next section.

How the employer penalty for dropping coverage actually becomes an incentive to drop coverage

Employers with 50 employees or more are penalized under PPACA for not providing health care coverage. The intent is to prevent employers from dropping existing coverage and increasing the burden on subsidized exchanges.

But the size of the penalty compared with the amount most employers contribute for health insurance quickly shows why there is actually an incentive for employers to drop coverage, not the reverse as the law intended.

In 2009 Tennessee employers made an average contribution of \$3,539 for single health insurance coverage for an employee. The figure was \$8,344 for family coverage and \$6,379 for employee-plus-one coverage.

The following example shows the net financial impact per employee for an employer who drops coverage. The example uses family coverage costs*:

Savings of the employer contribution	\$8,344
PPACA employer penalty for dropping coverage	-\$2,000
Gain to employer	\$6,344

In this example, by dropping coverage and accepting the PPACA penalty the employer receives a substantial gain.

In Tennessee this “penalty” results in an employer savings of \$1,539, \$6,344 and \$4,379 when the employer drops single, family or employee-plus-one coverage respectively, in 2009 dollars; a point also made by former Tennessee Governor Phil Bredesen in *The Wall Street Journal*.¹²

¹² Philip Bredesen. ObamaCare's Incentive to Drop Insurance. *Wall Street Journal*. October 21, 2010. Available at: <http://online.wsj.com/article/SB10001424052702304510704575562643804015252.html>

* Tax implications may apply

If all Tennessee employers were to drop coverage in 2014 they likely would experience a savings of approximately \$4.4 to \$4.5 billion in 2009 dollars or about 1.8% of Tennessee state gross domestic product – a savings that would repeat every year. If all employers nationally were to drop coverage in 2014, extending the Tennessee figures for savings and not considering that small employers receive no penalty, it could create a savings to those employers of approximately \$231 billion in 2009 dollars or about 1.64% of national GDP.

As a consequence of the incentive to drop health care coverage, in theory the reduction in funding for health care could be as large as \$1.9 trillion from 2014 through 2019. This reduction would have to be replaced in some form. These estimates do not reflect the fact that companies with fewer than 50 employees pay no penalty for dropping coverage, which would make the possible savings to employers even greater.

In practice, it is unlikely that the actual savings to employers would be as large as indicated above or last permanently, nor would the reduction in funding for health care be as large. If large numbers of employers drop coverage, it is likely that the government would increase the penalty for not providing insurance. In addition, employers likely would not retain all the savings – rather they would transfer at least part of it to employees moving to the exchange in the form of increased compensation to help underwrite their health insurance costs.

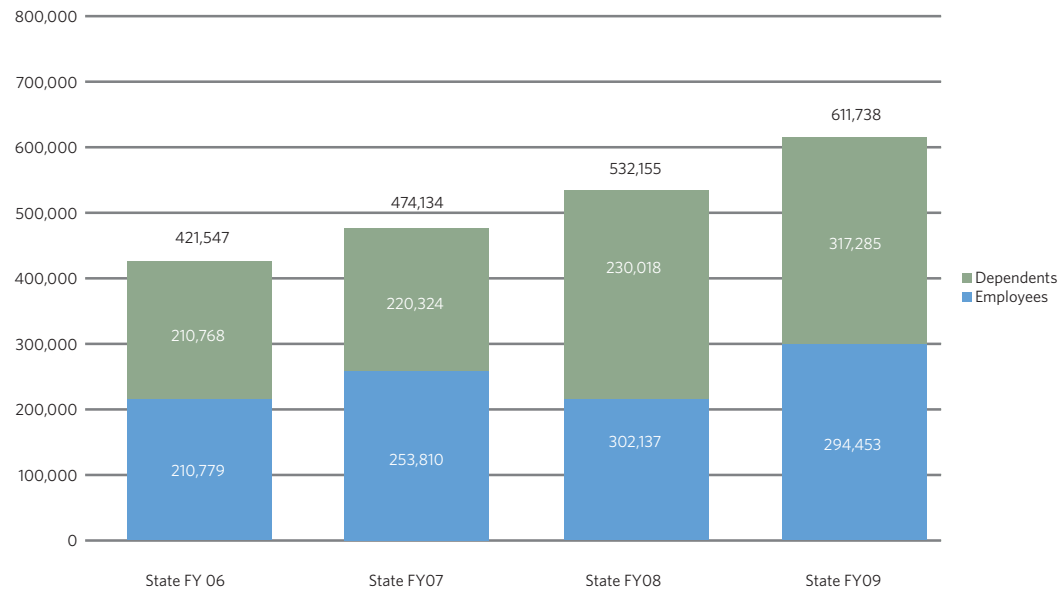
It is important to note that employers already (prior to PPACA) have a financial incentive to drop health insurance coverage. There is no penalty currently if coverage is dropped, and the same savings (without the penalty) cited above would occur. However, many employers continue providing coverage. This is because many feel a responsibility to do so, knowing that their employees could not afford or, more important, would not qualify for coverage in the private market. Under PPACA, this problem is removed because of the creation of the exchanges.

We have previously alluded to the “grandfather” clause of the new law. This essentially states that those plans that do not change in any way from the employer sponsored plan in effect as of March 23, 2010, are exempt from most of the provisions of the new law (with the exception of certain new requirements such as coverage to age 26 for children.) The assumption is that if an employer relinquishes its grandfather status, it is likely to stop providing health insurance to employees. The IRS estimates of employers that would relinquish their grandfather status was based on the experience of health plan turnover among employers when there was *no additional incentive* for employers to drop coverage, including the new mandates under PPACA.

The only citable experience with employer behavior under reform with exchanges is from Massachusetts where there are signs of increased employer coverage cancellation. (See Figure 2.) More Massachusetts employees (from companies with 50 or more employees) and their dependents are now insured through public assistance.¹³

¹³ Employers Who Had Fifty or More Employees Using MassHealth, Commonwealth Care, or the Health Safety Net in State FY09. Massachusetts Division of Health care Finance and Policy, June 2010.

Figure 2. Total number of employees and dependents using public assistance in Massachusetts after reform



Percent Change

	Employees	Dependents	Overall
State FY06 to State FY07	+5.9%	+4.5%	+5.2%
State FY07 to State FY08	+19.0%	+4.4%	+12.2%
State FY08 to State FY09	-2.5%	+37.9%	+15.0%

The Massachusetts experience shows that employers and employees will, over time, take advantage of the incentives under PPACA to shift from traditional employer-sponsored coverage to coverage obtained through a health insurance exchange. The employer decision-making process about whether to drop coverage will be complex and likely based on competitive pressures in addition to new government policy that will require employers who provide health insurance to incur the additional costs newly required under the law.

Questions employers will ask under the new law:

1. What are the advantages and disadvantages to our employees of health exchange coverage compared to traditional employer-sponsored coverage?
2. Does our current health insurance offering provide the “actuarial value” and new benefits mandated under PPACA? If not: What is the cost of adding the new benefits and maintaining the “actuarial value” required by PPACA? (Actuarial value is the percentage of health care costs covered by insurance for a typical enrollee.)
3. How long can we remain profitable and continue to cover the new and more costly health care coverage liability created by PPACA?
4. Should a defined benefit for health care replace our current coverage approach?
5. How will a decision to drop coverage affect employee recruitment and retention?
6. If our competitors take advantage of the incentives under PPACA to drop coverage will we remain competitive if we do not?

Questions an employee will ask:

1. Will my employer be able to continue offering health insurance?
2. Is the employer contribution to my premium less than the premium subsidy I could receive by buying exchange-based insurance?
3. What is the value of the cost sharing subsidy to me compared to the employer contribution to my premium?
4. Will the employer share of my premium continue to be the same over time?
5. How does health insurance through my employer affect my ability to change jobs compared to insurance through the exchange?

Premium impact of PPACA In Tennessee

There are several provisions of PPACA that will affect how premiums are rated. How much a person pays will be dependent upon their income level and whether they qualify for Medicaid or premium subsidy. Unless an employer is “grandfathered,” which means that it does not alter the health care benefit plan that was in effect March 21, 2010, for its employees, it will be subject to the following rules, which apply both within the exchange, and in the private market.

1. **Guaranteed Issue.** Commonly referred to as “pre-existing conditions” (which has a different meaning in insurance lexicon). Requires that an insurer must accept anyone who applies for insurance, without regard to any health conditions that person may have. Stated another way, you can wait until you get sick to buy insurance. It is like waiting until you have a wreck to buy car insurance. Obviously, this provision will drive premium rates higher. Of course, if you are already sick and can’t get insurance, this provision is helpful. If you are healthy, and already have insurance, this provision will likely raise your premium costs.
2. **3:1 Compression Ratio.** Under current law, insurance companies, for the most part (with community rating states being the exception) charge more for older, sicker people than they do for younger, healthy ones. Currently, the highest premium is up to 10 times the lowest. Under PPACA, this “compression ratio” is reduced to a maximum of 3 to 1. If you are 60 years old and have high blood pressure and diabetes, this will reduce your health insurance premium; if you are 25 and healthy, this will raise your health insurance premium.

Those are the major factors that will influence how premiums are rated in Tennessee. There are other issues such as the new insurer tax (which is \$8 billion in 2014) apportioned based on premium, which increases each year for five years, (see the “Where does the money come from?” in the Appendix). Another issue is the new tax on drugs and medical devices (which will be passed on to the end user, like all taxes, in the form of higher premiums), and mandated benefits that today are optional, such as preventive care.

How the premium impact will affect real people

First, consider the case of a 25-year-old man with no health risks (doesn’t smoke, normal body weight, and no known chronic conditions). Today, for a standard policy (see Appendix for details), this person will likely pay \$125 per month in premiums. Under PPACA, he will likely pay \$233.

Next, consider a family, where the mother and father are 44 and 45, with two children. Under current law, they pay \$701 per month. Under PPACA they will likely pay \$1076 per month.

Lastly, consider a couple age 63, with health issues. Today, they pay \$1020 per month; under PPACA, \$849.¹⁴

Under PPACA, if you are poor, whether you are young and healthy or old and sick, you will be better off because of the federal subsidies. If you are middle class or upper class, you are going to pay more than you do today, unless you are older and sicker. In other words, the very people who are needed to keep the pool affordable, i.e., the young, healthy, and higher income earners, will have the greatest adverse impact under the new law.

The individual mandate

PPACA requires all individuals residing legally in the U.S. to buy health insurance or pay a penalty for not doing so. (There is no such requirement for illegal immigrants, though the provisions of the Emergency Medical Treatment and Active Labor Act remain in effect. They require any facility receiving federal funds to provide care to any person presenting with an illness that threatens life or limb, regardless of legal status.)

The penalty is the greater of \$695 per year up to a maximum of three times that amount (\$2,085) per family or 2.5% of household income, whichever is less. This is to be phased in as follows:

2014: \$95 or 1%

2015: \$325 or 2%

2016: \$695 or 2.5%

After 2016 it will be indexed to CPI.

One of the primary principles of insurance is that risk is spread around among many people. In its purest form, it works something like this: 1,000 people buy car insurance because, statistically it is known that in any given year (2003 for these specific statistics), about 15 of those people are going to have a very serious wreck, another 18 or so will have a wreck without injury and one of 4,600 will have an accident in which a death occurs.¹⁵ It is unpredictable who will have a wreck, although those with more of a tendency to do so (young drivers, for instance) will pay more for coverage. Those people who have wrecks will get money from the insurance company, and the other 967 or so people will have paid in and will have received no money (although they have had the peace of mind that comes with knowing that if they did have a wreck, it would be covered). If one of the insured people is very careless and has multiple wrecks, or gets convicted of driving while intoxicated, the insurance company will drop that person from coverage.

¹⁴ Calculations provided by Jim Srite, Chief Actuary at BlueCross BlueShield of Tennessee.

¹⁵ Car Accident Statistics. Available at: <http://www.car-accidents.com/pages/stats.html>

Health insurance does not work that way. First of all, it pays for many things that are predictable and desirable, like routine doctor visits, preventive care and prescription drugs for chronic illness. So part of the premium goes for what we would term “pre-paid medical care.” The older we get, the more “routine maintenance” we require. This is somewhat like the escrow you pay on your mortgage so that when your tax or homeowner’s insurance becomes due, your mortgage company pays these bills on your behalf. It is, however, your money, which you have paid in throughout the year.

For those illnesses that are unexpected, health insurance works more like regular insurance, (except that most companies do not drop people from coverage for getting sick.). Actuaries can predict, fairly accurately, based on age and sex and previous illness patterns, how much any given population, if large enough, will spend on health care. The older and sicker the population, the more each person has to pay to have enough money in the pool to pay expenses. That is why it is important to have as many people in the pool who are young and healthy if the goal is for premiums to remain affordable.

Young healthy 25 year olds, making \$50,000 per year, must choose between paying \$220 per month for health insurance, or taking that same money and making a car payment or buying another product or service which they are likely to perceive as more important. Knowing that if they get sick, they can always buy health insurance (as under PPACA) adds to the incentive to delay purchase of health insurance. *This is why PPACA requires that everyone buy health insurance or pay a penalty.* That is what the term “individual mandate” means. (We won’t discuss here the adequacy of the penalty; there is little, if any, convincing data as to how much the mandate needs to be to be effective.)

Three researchers¹⁶ writing in the January 27, 2011, edition of the New England Journal of Medicine, have shown that in the Massachusetts connector experience, “clearly the mandate brought many more healthy [people] into the risk pool. The large jump in healthy enrollees that occurred when the program became fully effective suggests that the enrollment by the healthy was not simply slower than enrollment by the unhealthy, but rather that the mandate had a causal role in improving risk selection.”

The individual mandate, while potentially making the reforms in PPACA effective and more affordable for those with high health care costs, is controversial legally. Advocates point to its necessity for making health insurance affordable for others while opponents claim it is unconstitutional to require that a citizen purchase a private product or service. As of this writing, three judges have upheld this challenge and two have rejected it. It is expected that this will require a ruling by the U.S. Supreme Court. In the meantime, preparations for implementation of PPACA at the state level are subject to the political atmosphere of any given state. This, obviously, increases the likelihood of uneven and flawed implementation.

¹⁶ Chandra, A., Gruber, J., and McKnight, R. NEJM 364;4 pp293-5

PART 3: INCREASE IN STATE FUNDING REQUIREMENTS

Nationwide spending related to PPACA

Over the 2010-2019 period CMS estimates:¹⁷

- 1) The effect of PPACA on health care spending will be an increase of \$251.3 billion
- 2) That Medicare spending will be reduced by \$575.1 billion.



The Medicaid expansion in Tennessee

An approximation of total and state spending on Medicaid for Tennessee for both PPACA and the original law is shown in the figure below:

Figure 3. Estimate of spending on Tennessee Medicaid

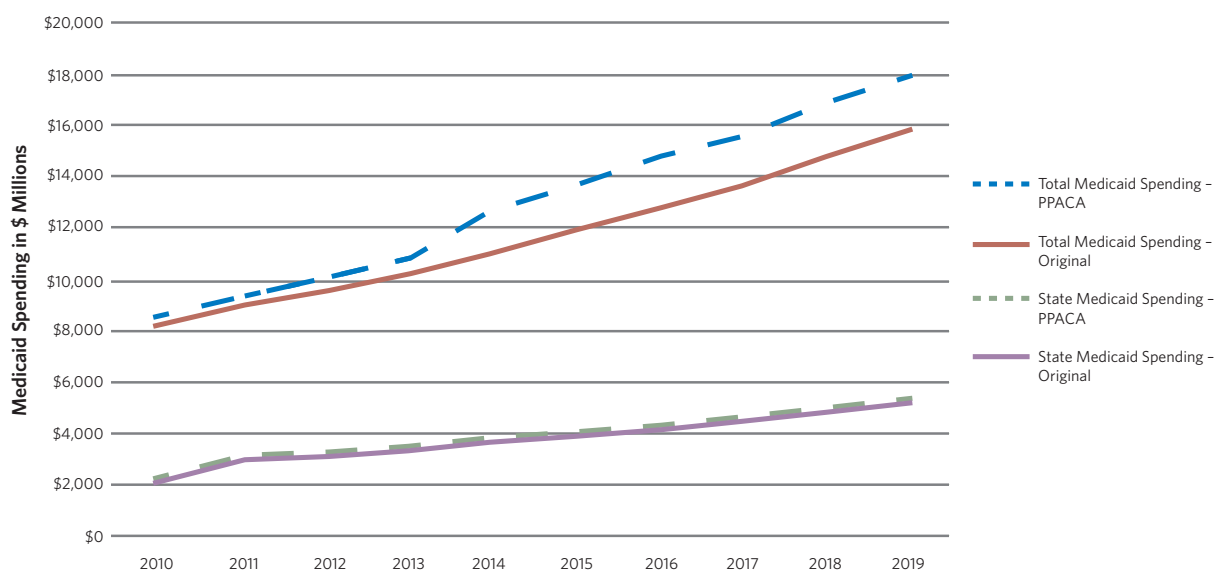


Fig. 3 shows both the Tennessee state Medicaid spending (the lower two lines) as well as the total spending for Medicaid in Tennessee. The total includes the “federal match,” which is the amount of money paid by the federal government. The federal match is the result of a complicated formula that is different for each state, but that “matches” money put into the program by the state. As you can readily see, the federal contribution exceeds the state contribution by about 2:1. You can also see that the two lower lines are virtually superimposed on each other. That is because PPACA has a relatively small impact on the amount that Tennessee has to put in. The total increase is \$1.2 billion over 10 years. That is not exactly chicken feed, but in reality, only about 1% of the state-funded portion of the state budget.

By 2019, the state will be spending about \$5.5 billion per year on Medicaid, which is only approximately \$120 million more than it would have under current law.

¹⁷ Based on updated projections for 2009-2019 as of September 2010.

The federal spend, on the other hand, takes a fairly dramatic increase in 2014, when the full provisions of the law kick in. By 2019, the total annual spend (federal and state together) will be \$18 billion, where it would have been \$16 billion under the old law. Over the total of the 10 years, this difference amounts to almost \$13 billion.

In other words, in Tennessee, we will be drawing down about \$11.8 billion in additional dollars from the federal government (i.e. the “rich states”) than we would have previously. In other words, we are “winners.” (see Fig 1 p. 5)

Other financial factors impacting the state:

- Total federal taxes collected in Tennessee are expected to increase by \$9.19 billion as a consequence of PPACA. Increased federal tax and Medicaid spending from the state will cost \$10.1 billion over the projected period. Tennessee receives a net benefit from this new spending of \$2.59 billion through 2019, i.e., new federal money coming in to support Medicaid vs. new federal taxes on Tennesseans (see Appendix).
- Of the \$10.1 billion in new state spending on Medicaid approximately \$1.52 billion would have been spent on health care under the prior law while the entire amount will be spent on health care under PPACA; this means a shift of \$8.58 billion from other economic sectors to health care through 2019, an average of \$858 million per year.
- In 2009, sectors other than health care were responsible for \$221 billion of gross domestic product for Tennessee. The PPACA shift represents 0.39% of the GDP of the non-health care economic sectors in 2009 prior to PPACA enactment and would be less than 0.39% of state GDP in 2014 when the law is enacted.

CONCLUSIONS



For purposes of this paper, we have assumed perfect implementation of PPACA. Naturally, that is not going to be the case. A bill of over 2,000 pages, with regulations that will be some multiple of that, is too complex for human beings to implement “on-time and on-budget.” Add to that the ambiguity of the law itself in many places and implementation is likely to be very difficult, if not impossible. We have not attempted here to elucidate all of these possible “failure points,” or, for that matter, any of them. Our purpose was to delineate the *intended* impact of the bill, not to anticipate all the potential unintended consequences.

Unless materially altered, PPACA will, on the national front:

- Add health insurance coverage for between 19 and 26 million people, in large part by expanding Medicaid eligibility, and in small part by eliminating pre-existing condition exclusions.
- Alter where people get insurance. Private health insurance, which normally would be expected to grow to 194 million due to the recovering economy will actually decrease to 180.7 million or less due to an incentive inherent in PPACA for employers to drop coverage.
- Decrease the private individual market by roughly 60%, and the people currently covered in this manner will get health insurance through the exchange.
- Not increase the capacity of the medical system, although there are some minor inherent improvements in reimbursement for primary care physicians.
- Shift primary responsibility for the cost of health care from employers to the federal government and individuals through the creation of “exchanges” and incentives for employers to drop health care coverage.

As a consequence of this shift, there will be winners and losers:

- The economically disadvantaged and/or those who have significant health care conditions who are not today covered will be winners.
- Older, less healthy people under the age of 65 will be winners because their costs of coverage will decrease.
- Employers will be short-term winners because their health care costs will be \$1.9 trillion less than prior to PPACA.
- Those who currently have health insurance will be losers because they will experience longer wait times for care and for the most part will find their costs going up.
- Young and healthy people will generally be losers because their costs of coverage will rise at least two- to three-fold due primarily to the 3:1 compression ratio. The compression ratio limits the size of the most expensive premium to three times that of the least expensive. Currently, young people typically have the lowest premiums because they are in the best health. The exception to this will be that subset of young people who qualify for a significant subsidy or for Medicaid.
- Taxpayers will be losers because of the new taxes contained in PPACA. (In Tennessee, for example, they total approximately \$9.2 billion.) See Appendix table 32 for a list of the new taxes.
- States will be losers because they will see their costs of Medicaid go up by \$61 billion over the 10-year period. By 2019, the rate of state and local spending will be \$7.7 billion per year more than under current law.
- Providers will be losers because they will find themselves in a market that has *de facto* price controls, and will see their real dollar income drop over time.
- Rich states will be losers and poor states winners.

- Taken together, these conditions will create an environment that favors the development of a “luxury medicine” industry, the precursor of which is seen today in the concierge medicine movement.
- There will be unintended and unpredicted consequences, in large part due to the complexity of the new law and its attendant regulations.

In Tennessee:

- There will be an estimated 683,000 newly covered individuals.
- There will be a net influx of money from the federal government of about 1% of Gross State Product (\$3 billion over 10 years).
- There will be a net increase of roughly 660,000 members in Medicaid, about two-thirds of which will be from the ranks of the uninsured, and one third who will be from the ranks of the currently insured.
- In 2014, approximately one million people who currently receive coverage through their employers will be covered through the exchange. During the subsequent four years, the vast majority of employers will likely drop health insurance coverage and their employees will have to seek coverage under the exchange.
- For those under approximately 200-250% of the federal poverty level, most will pay less out of pocket than they do today for medical care. Those over that level will pay more, in some cases substantially more.
- In short, some may view PPACA as a wealth transfer from the healthy to the sick, from the wealthy to the poor and middle class, and from the young to the middle-aged. It is, for the most part, consistent with the social policy that established Medicaid and Medicare. However, due to the complexity of PPACA (multiple levels of coverage, multiple levels of subsidy, multiple insurers to choose from) and the level of controversy surrounding this act, it remains to be seen whether this can be implemented as currently written.

LOOKING AHEAD IN TENNESSEE

In this paper, we, the authors, have described three impacts that the new health care law will have on Tennessee. There are numerous issues to be resolved, but we would like to present three that Tennessee's leaders ought to place a priority on addressing.

Primary care capacity

The issue of Tennessee's supply of primary care providers seems not to be recognized or appreciated at any sort of central level within the state. Different groups are forging different solutions that may or may not be effective and compatible with other solutions.

There are five medical schools in Tennessee. It would seem reasonable for the state to facilitate the development of an overall primary care strategy that involves the medical schools and the residency programs within the state. Increasing the supply of new practitioners is not as easy as simply expanding the number of primary care residencies.

In Massachusetts, which has the nation's best supply of primary care physicians relative to its newly covered population, numerous anecdotes attest to the increasing unavailability of primary care appointments. Imagine what the impact will be in Tennessee, where we are starting from a much shorter supply of practitioners. In addition to an increased number of primary care physicians, we are going to need some structural realignment in the way care is delivered. This will take time, energy and thought, and needs to begin as soon as possible.

Funding

Even though much of the cost will be borne by the federal government, there will still be the matter of about \$1.2 billion in new expense to the state of Tennessee between 2014 and 2019.

This will require some decisions about budget priorities. The sooner that leaders focus on these questions, the more thoughtful the process can be.

Administration

The administrative complexity of PPACA cannot be overstated. Fortunately, the Bureau of TennCare seems to understand this and is working on a plan. Under the new law, states are given the option of setting up the exchanges that will operate within their boundaries. Tennessee has chosen to do that. The sooner questions are answered regarding the exchange, (which are beyond the scope of this paper) the more likely it is that implementation will be successful.

APPENDIX

Tables 7 & 8. The health exchanges and premium subsidies

Estimates for “Reference Plan” in 2016-2nd Lowest Cost “Silver Plan

	Actuarial Value	Average Premium	Avg. Cost Sharing
Single Policy	70%	\$5,200	\$1,900
Family Policy	70%	\$14,100	\$5,000

Single Person								
Income Relative to the FPL	Premium Cap as a Share of Income/a	Middle of Income Range/ b,c	Enrollee Premium for Low-Cost “Silver” Plan	Premium Subsidy (share of premium)	Average Cost Sharing Subsidy	Average Net Cost Sharing	Enrollee Premium + Avg. Cost Sharing	
							Dollars	Percent of Income
100-150% /d	2.1%-4.7%	\$14,700	\$300	95%	\$1,100	\$800	\$1,100	7%
150-200%	4.7%-6.5%	\$20,600	\$1,200	77%	\$600	\$1,300	\$2,500	12%
200-250%	6.5%-8.4%	\$26,500	\$2,000	62%	-	\$1,900	\$3,900	15%
250-300%	8.4%-10.2%	\$32,400	\$3,000	42%	-	\$1,900	\$4,900	15%
300-350%	10.2%	\$38,300	\$3,900	25%	-	\$1,900	\$5,800	15%
350-400%	10.2%	\$44,200	\$4,500	13%	-	\$1,900	\$6,400	14%
400-450%	N/A	\$50,100	\$5,200	0%	-	\$1,900	\$7,100	14%

Family of Four								
Income Relative to the FPL	Premium Cap as a Share of Income/a	Middle of Income Range/ b,c	Enrollee Premium for Low-Cost “Silver” Plan	Premium Subsidy (share of premium)	Average Cost Sharing Subsidy	Average Net Cost Sharing	Enrollee Premium + Avg. Cost Sharing	
							Dollars	Percent of Income
100-150% /d	2.1%-4.7%	\$30,000	\$600	96%	\$3,300	\$1,700	\$2,300	8%
150-200%	4.7%-6.5%	\$42,000	\$2,400	83%	\$1,800	\$3,200	\$5,600	13%
200-250%	6.5%-8.4%	\$54,000	\$4,000	72%	-	\$5,000	\$9,000	17%
250-300%	8.4%-10.2%	\$66,000	\$6,100	57%	-	\$5,000	\$11,200	17%
300-350%	10.2%	\$78,000	\$7,900	44%	-	\$5,000	\$12,900	17%
350-400%	10.2%	\$90,100	\$9,200	35%	-	\$5,000	\$14,200	16%
400-450%	N/A	\$102,100	\$14,100	0%	-	\$5,000	\$19,100	19%

Source: Congressional Budget Office and the Staff of the Joint Committee on Taxation

Notes: All dollar figures have been rounded to the nearest \$100; N/A = not applicable; FPL = federal poverty level

^a In 2014, the income-based caps would range from about 4% at 133% of the FPL to 9.8% at 300% of the FPL, and that 9.8% cap would extend to 400% of the FPL; in subsequent years those caps would be indexed.

^b In 2016, the FPL is projected to equal about \$11,800 for a single person and about \$24,000 for a family of four.

^c Subsidies would be based on enrollees’ household income, as defined in the bill.

^d Under the bill, people with income below 133% of the FPL would generally be eligible for Medicaid and thus ineligible for exchange subsidies; the premium cap in 2014 for those with income below 133% of the FPL would be 2% of income.

“Reference plan” in this context refers to the next-to-lowest cost plan (which is the “silver” or 70% actuarially valued) plan. When the “Premium cap” is applied to a family’s income, that means there is a limit to the percentage of a family’s income that PPACA says should go to pay for medical insurance, and since there are multiple plans to choose from, that cap is applied to the “reference plan’s” premium.

For example, in the first table, if a single person’s income is between 300% and 350% of the federal poverty level – say \$38,300 for purposes of this example), the most the law says that person should have to pay for insurance is 10.2% of income, or \$3,900 (the premium cap). Since the actual premium for the “reference plan” is \$5,200, that person would be eligible for a 25% subsidy, or \$1,300. At that level, he/she would still be responsible for \$1,900 in cost sharing (co-pays, deductibles, etc.) bringing that person’s total potential liability for medical care for that year to \$5,800 (\$3,900 + \$1,900), or 15% of total income.

At the lower end of the scale, between 150% and 200% of FPL (\$14,700 for this example), the law says that person should pay no more than 2% of his/her income (the “cap”) for health insurance, which equates to \$300, and the person would get a subsidy of \$4,900. Furthermore, in this income range, the federal government will also subsidize the out-of-pocket expenses by another \$1,100, so the total potential cost to the beneficiary is \$1,100 (\$300 + \$800), or 7% of income.

These rules are fairly complex. When you add to that the fact that people’s incomes change significantly over time (after four years, only 20% of people who started out below 133% of poverty have stayed below that level according to a study by Sommers and Rosenbaum in the February 2011 issue of Health Affairs) you can begin to see how complicated this will be to implement accurately.

Demographics and premium subsidies

The next four maps of Tennessee show where people who are eligible for a premium subsidy under the new PPACA exchange live, and their current sources of coverage. The first shows the number of people who currently have coverage through their employer; the second shows the number of people who currently purchase their own individual health insurance; the third shows the people who are currently insured; the fourth is the total. Altogether these show that the distribution of subsidy-eligible people pretty much follows population patterns, and there are a large number of people who already have private health insurance who will become eligible for a subsidy under PPACA.

Figure 4. Employer provided premium subsidy eligible

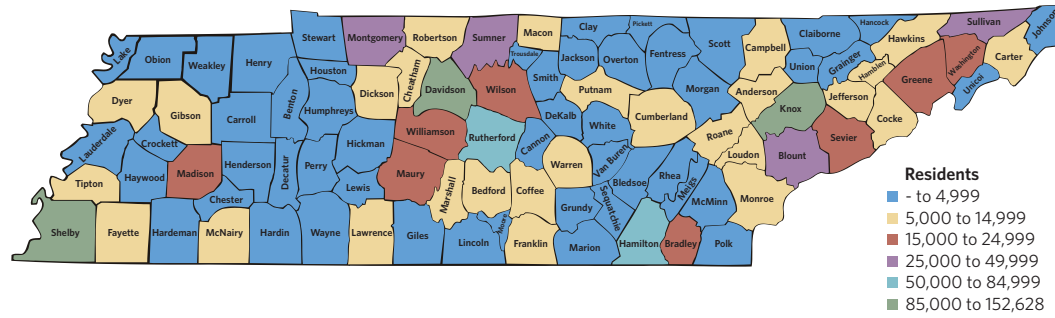


Figure 5. Direct purchase premium subsidy eligible

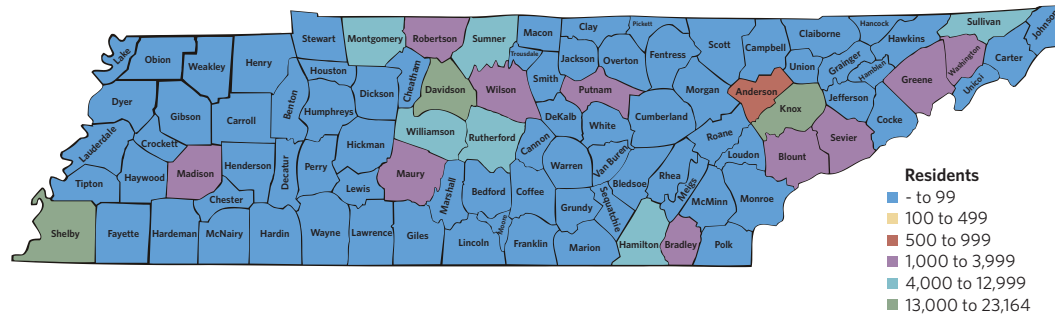


Figure 6. Uncovered premium subsidy eligible

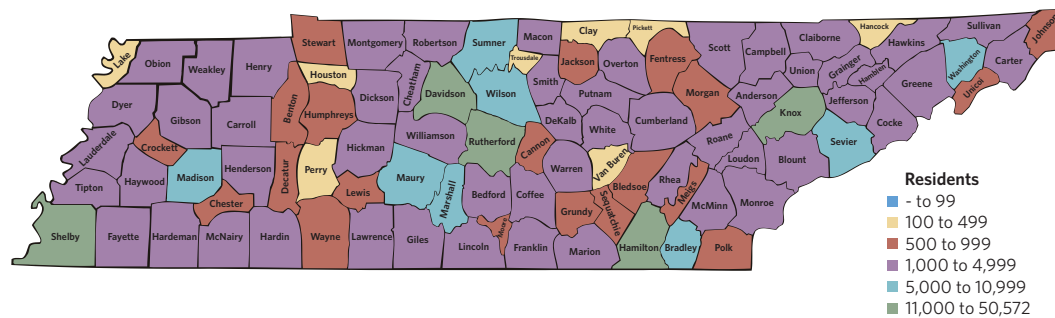
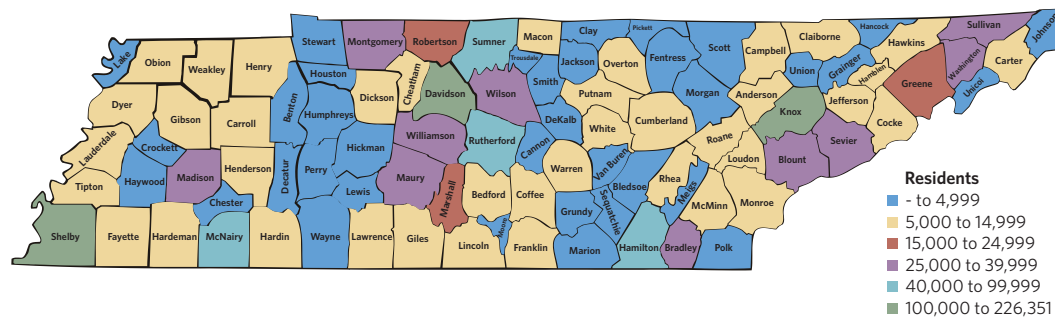


Figure 7. Total premium subsidy eligible



Those newly eligible for Medicaid

These four maps show the same thing, except they refer to people newly eligible for Medicaid. Again, these people are distributed roughly in the same proportion as the general population, and again, it is noteworthy that a significant fraction (as discussed in the main body of the paper) currently has coverage.

Figure 8. Employer sponsored Medicaid expansion eligible

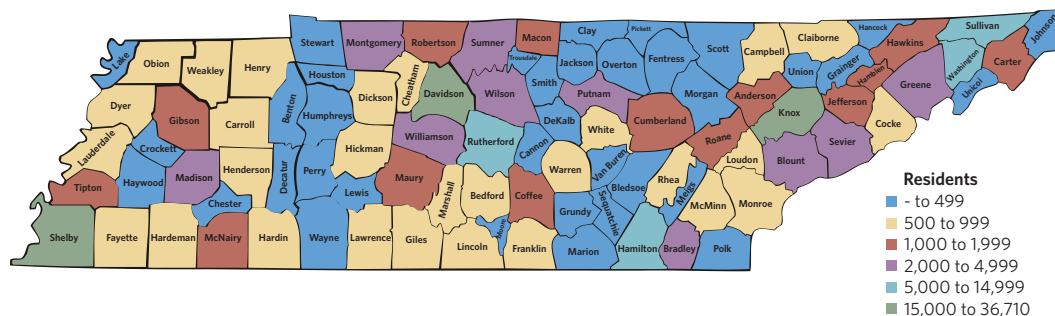


Figure 9. Direct purchase Medicaid expansion eligible

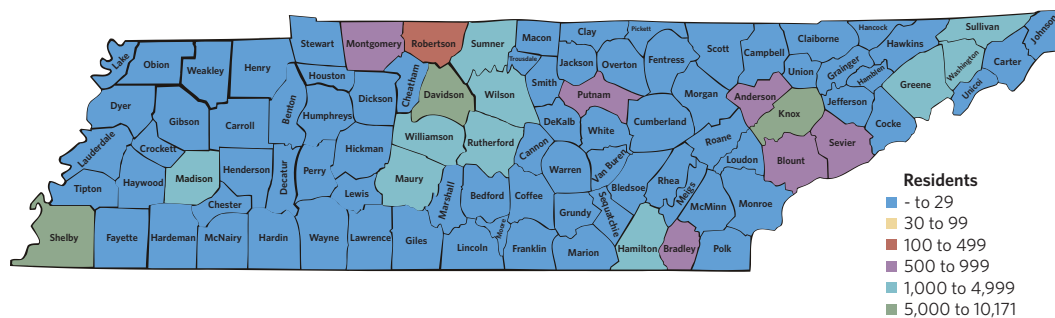


Figure 10. Uncovered Medicaid expansion eligible

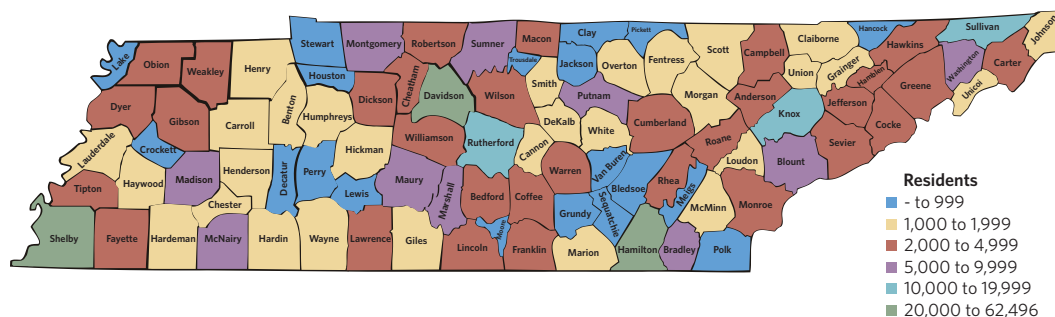


Figure 11. Total Medicaid expansion eligible

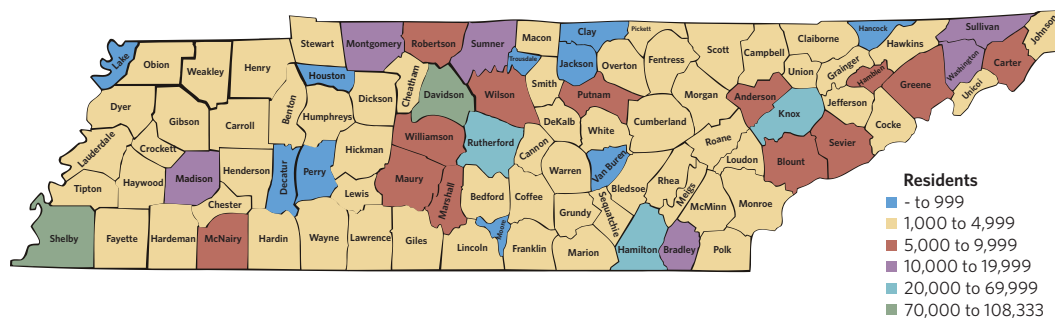


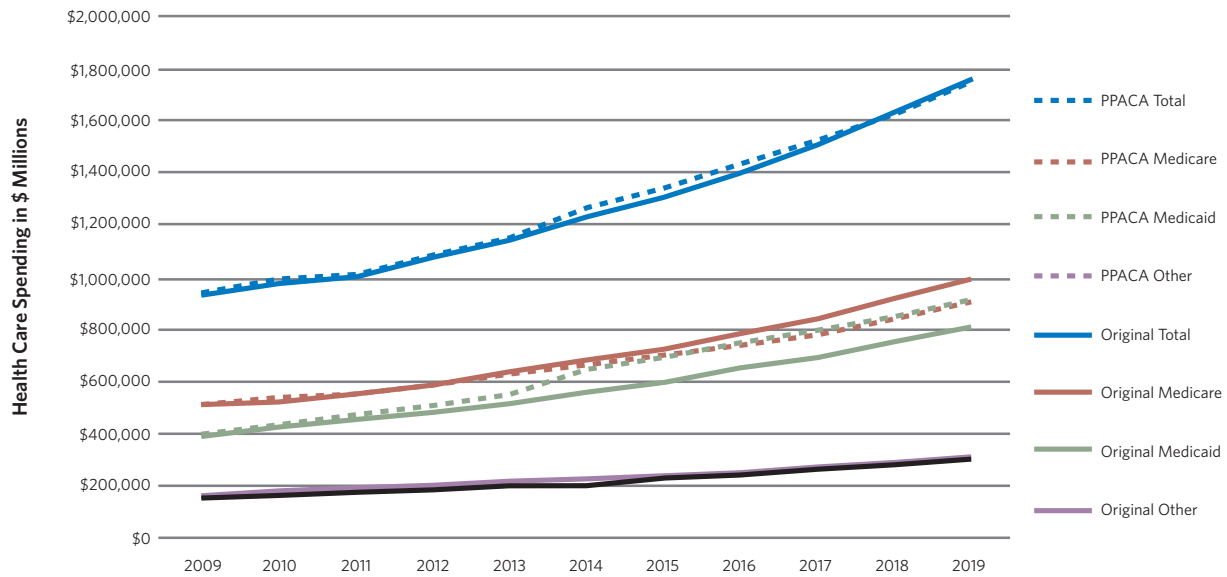
Table 9. Current ratio, Medicaid to Medicare, by State

Medicaid to pay no less than Medicare for visits and vaccines by primary care physicians (2013-2014)

State	Ratio	State	Ratio	State	Ratio
Alabama	0.78	Kentucky	0.80	North Dakota	1.01
Alaska	1.40	Louisiana	0.90	Ohio	0.66
Arizona	0.97	Maine	0.53	Oklahoma	1.00
Arkansas	0.78	Maryland	0.82	Oregon	0.78
California	0.47	Massachusetts	0.78	Pennsylvania	0.62
Colorado	0.87	Michigan	0.59	Rhode Island	0.36
Connecticut	0.78	Minnesota	0.58	South Carolina	0.86
Delaware	1.00	Mississippi	0.84	South Dakota	0.85
District of Columbia	0.47	Missouri	0.65	Tennessee	N/A
Florida	0.55	Montana	0.96	Texas	0.68
Georgia	0.86	Nebraska	0.82	Utah	0.76
Hawaii	0.64	Nevada	0.93	Vermont	0.91
Idaho	1.03	New Hampshire	0.67	Virginia	0.88
Illinois	0.57	New Jersey	0.41	Washington	0.92
Indiana	0.61	New Mexico	0.98	West Virginia	0.77
Iowa	0.89	New York	0.36	Wisconsin	0.67
Kansas	0.94	North Carolina	0.95	Wyoming	1.17

Source: Adapted from S. Zuckerman, A. F. Williams, and K. E. Stockley, "Trends in Medicaid Physician Fees, 2003-2008," Health Affairs Web Exclusive, April 28, 2009, w510-w519.

Figure 12. Federal health care spending projections



Where does the money come from?

The CBO estimates that the cost of PPACA will be \$938 billion over 10 years (from 2009 until 2019). This is a bit misleading in that most of the new taxes begin prior to 2014, and most of the expenditures under the law begin in 2014.

Government programs can be funded three ways: increased or new taxes, spending less on other programs, or debt.

There are 10 new taxes under PPACA and some new reporting requirements, all with varying effective dates:

New Revenue (Tax) Provisions

1. A 40% excise tax on health coverage premiums in excess of \$10,200/\$27,500 (subject to adjustment for unexpected increase in medical costs prior to effective date) and increased thresholds of \$1,650/\$3,450 for over age 55 retirees or certain high-risk professions, both indexed for inflation by CPI-U plus 1%; adjustment based on age and gender profile of employees; vision and dental excluded from excise tax; levied at insurer level; employer aggregates and issues information return for insurers indicating amount subject to the excise tax; nondeductible
2. Employer W-2 reporting of value of health benefits

Source: Centers for Medicare and Medicaid Services

3. Conform the definition of medical expenses for health savings accounts, Archer MSAs, health flexible spending arrangements, and health reimbursement arrangements to the definition of the itemized deduction for medical expenses (excluding over-the-counter medicines prescribed by a physician)
4. Increase additional tax on distributions from HSAs and Archer MSAs not used for qualified medical expenses to 20%
5. Limit health flexible spending arrangements in cafeteria plans to \$2,500; indexed to CPI-U after 2013
6. Require information reporting on payments to corporations (rescinded by Congress)
7. Additional requirements for section 501(c)(3) hospitals
8. Impose annual fee on manufacturers and importers of branded drugs (\$2.5 billion for 2011, \$2.8 billion per year for 2012 and 2013, \$3.0 billion per year for 2014 through 2016, \$4.0 billion for 2017, \$4.1 billion for 2018, and \$2.8 billion for 2019 and thereafter)
9. Impose 2.3% excise tax on manufacturers and importers of certain medical devices
10. Impose annual fee on health insurance providers (\$8 billion in 2014, \$11.3 billion in 2015 and 2016, \$13.9 billion in 2017, \$14.3 billion in 2018, and indexed to medical cost growth thereafter)
11. Study and report of effect on veterans health care
12. Eliminate deduction for expenses allocable to Medicare Part D subsidy
13. Raise 7.5% AGI floor on medical expenses deduction to 10%; AGI floor for individuals age 65 and older (and their spouses) remains at 7.5% through 2016
14. \$500,000 deduction limitation on taxable year remuneration to officers, employees, directors, and service providers of covered health insurance providers
15. Broaden Medicare Hospital Insurance Tax Base for High-Income Taxpayers – additional HI tax of 0.9% on earned income in excess of \$200,000/\$250,000 (not indexed), and Unearned Income Medicare Contribution on 3.8% on investment income for taxpayers with AGI in excess of \$200,000/\$250,000 (not indexed)
16. Modification of section 833 treatment of certain health organizations
17. Impose 10% excise tax on indoor tanning services

Other Provisions

1. Provide income exclusion for specified Indian tribe health benefits
2. Simple cafeteria plan nondiscrimination safe harbor for certain small employers
3. Qualifying therapeutic discovery project credit (sunset 12/31/10)
4. Exclusion for assistance provided to participants in state student loan repayment programs for certain health professions
5. Make the adoption credit refundable; increase qualifying expenses threshold and extend the adoption credit through 2011
6. Exclusion of unprocessed fuels from the cellulosic biofuel producer credit
7. Codify economic substance doctrine and impose penalties for underpayment
8. Increase by 15.75 percentage points the required corporate estimated tax payments factor for corporations with assets of at least \$1 billion for payments due in July, August, and September 2014

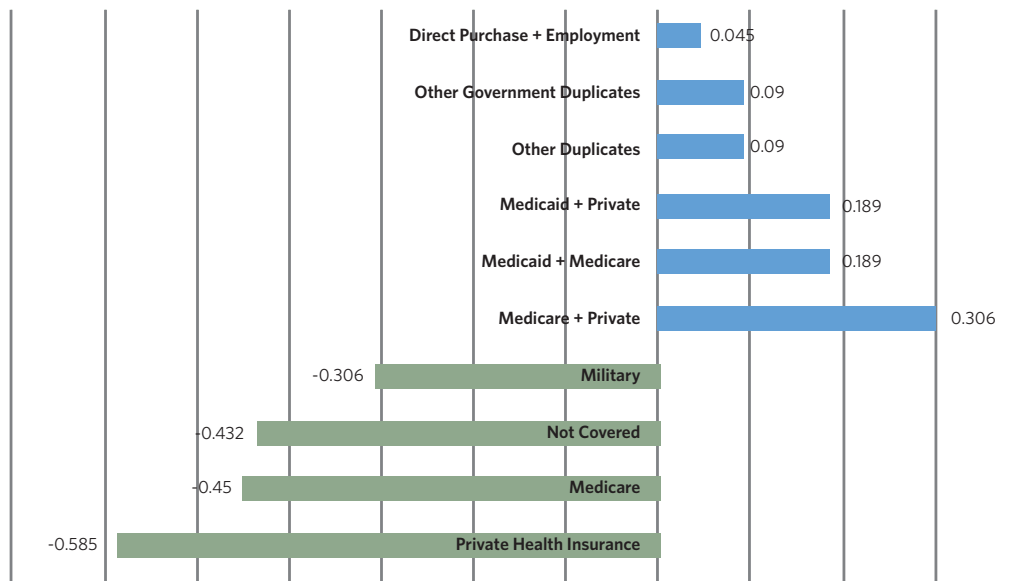
PPACA also reduces Medicare spending by an estimated \$575 million, primarily by cuts to Medicare Advantage, reduction in the disproportionate share payments, reducing market basket updates for hospitals, home health, skilled nursing facilities, hospice, and some other providers, and by establishing an Independent Payment Advisory Board whose charge will be to balance the budget through a complicated formula, which basically amounts to reducing physician fee schedules by an amount necessary to make up the difference between increased spending, and the reductions to Medicare and the additional taxes listed above.

If all of this fails, then there will be additional debt.

Tennessee Medicaid expansion/moderating factors on Medicaid eligibility

The Tennessee Medicaid segment of the health insurance market is sensitive to changes in other health insurance coverage segments. Changes in these market segments will influence the size of the Medicaid segment over time in addition to the PPACA policy changes that also change the size of the Medicaid segment.

Figure 13. 2009 TN Medicaid sensitivity to other market segments (Coefficients)



As an example, if the privately insured segment decreases by 10% the Medicaid segment will increase in size by 5.85%.

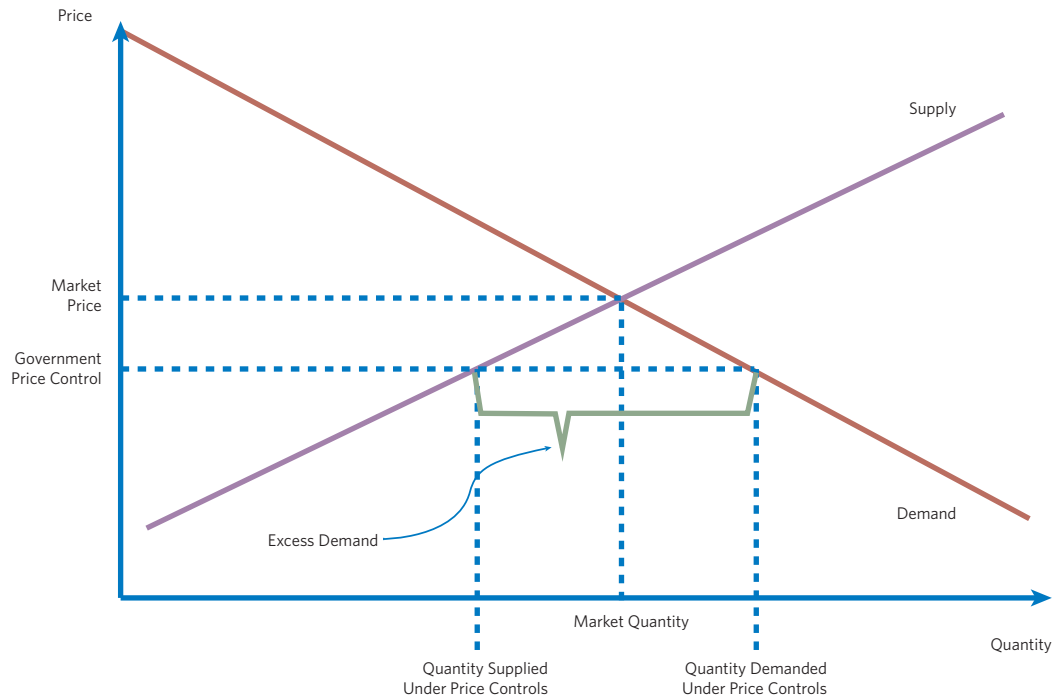
The size of the Medicaid segment is also sensitive to changes in the distribution of the population by the income/poverty ratio as shown in the table below. Changes in the economy for 2010 through 2013 will have an effect on the income/poverty distribution and, as a consequence, also affect the size of the Medicaid segment in addition to the policy changes in PPACA.

Table 10. Medicaid market segment sensitivity to income and poverty

State of Tennessee 2009		
Income to Poverty Ratio	Number	Change in Medicaid Segment for Every 100 People added to Income Segment
100% of Poverty	1,031,000	+129
100% to 200%	1,381,000	+35
200% to 250%	610,000	+48
250% to 300%	551,000	-2
300% to 400%	787,000	0
400% and Up	1,879,000	0
Total	6,239,000	0

With a mismatch of supply and demand, a price point that is fixed below market and no incentive for supply to increase, the access for those who previously had coverage will necessarily decrease.

Figure 14. PPACA and primary care capacity in Tennessee



The general effect of government price controls is shown in the price/quantity graph. When the government sets the price artificially low two things happen: 1) demand increases above that which would occur at the market price and 2) the number of suppliers willing to provide services at the government controlled price is lower than those willing to provide services at the market price. In the face of an existing primary care shortage, exerting price controls and even more regulation over an even larger portion of the population via Medicaid expansion is likely to reduce further the numbers of medical students that might enter primary care and/or the proportion of a primary care physician's practice that she/he will voluntarily allocate to Medicaid patients.

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Steven L. Coulter, M.D. joined BlueCross BlueShield of Tennessee as the Senior Vice President and Chief Medical Officer in 1997. He had progressive increases in his responsibilities and in April of 2005, he was promoted to President, Government Business and Emerging Markets. In that role, he had profit and loss responsibilities for Medicare, Medicaid, Medicare Advantage, and Shared Health. In January, 2011, he was appointed President of the BlueCross BlueShield of Tennessee Health Institute. The Institute does research and education regarding the economic and public policy aspects of health care with a focus on Tennessee.

Prior to moving to Tennessee, Dr. Coulter served as Senior Vice President and Chief Medical Officer at BlueCross BlueShield of Kansas City. From 1989 to 1992, he was Vice President and Medical Director at BlueCross BlueShield of Oklahoma. He was in the private practice of internal medicine from 1980 to 1989.

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William T. Cecil, M.B.A., is an independent health care consultant, whose practice is focused on health care reform, health care quality and health care economics. He has more than 30 years' experience as a health care executive in hospitals and managed care organizations. Cecil joined BlueCross BlueShield of Tennessee in 1995. As the Director of Health Policy Research at BlueCross BlueShield of Tennessee he was responsible for developing and administering consumer health care decision support systems. He also developed and authored white papers on health policy issues such as health care affordability and prescription drug use, among others, and has published in Journals such as Health Services Research, the Journal of Managed Care Pharmacy, The American Journal of Managed Care, Anesthesia and Analgesia, and the Journal of Clinical Monitoring.

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