Health Reform in CT: The HealthFirst Authority Proposal

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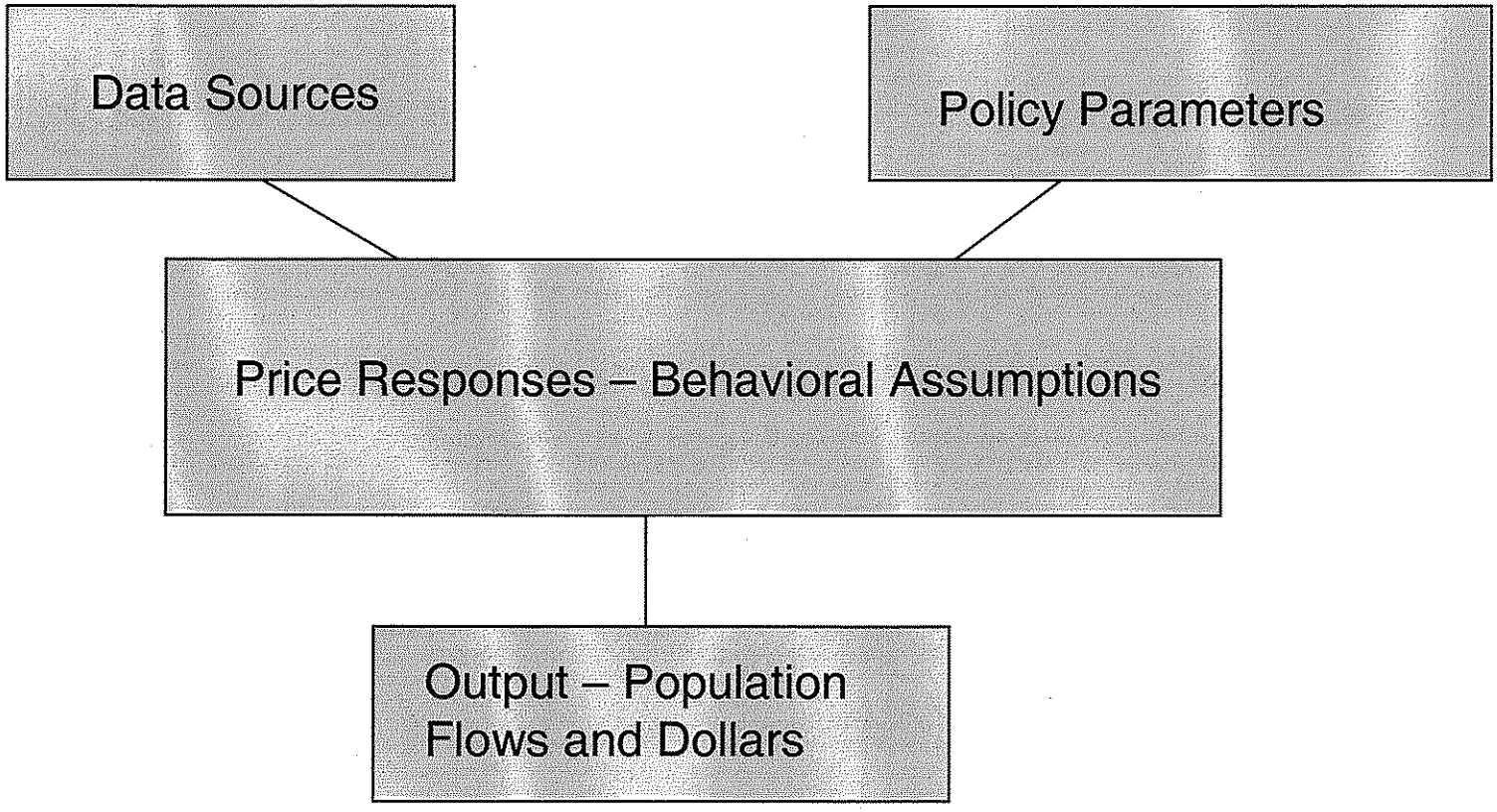
Outline of Talk

- Introduce myself and the GMSIM model
- Discuss the details of the HealthFirst proposal
- Present results of my analysis
- Discuss next steps

Who Am I? Why Am I Here?

- Professor at MIT since 1992 with focus on health economics
- Developed GMSIM model starting in 1999 as means of quantifying impacts of health reform
- Assisted Gov. Romney and Legislature with development of MA reform – and now serve on Connector Board
- Working or have worked with 10 states
- Working closely with Obama Administration & Congress on national reform

Schematic of the GMSIM Model



Connecticut-Specific Model

- Have developed a CT-specific version of this model with the generous funding of the Universal Health Care Foundation of CT
- Uses data specific to the state to get best estimates for state reform
- Basis for modeling of SustiNet Proposal
- Ongoing funding from Connecticut Health Foundation

HealthFirst Proposal Details

- Medicaid is made available, at no cost, to all state residents up to 185% of the Federal Poverty Level (FPL)
- Children receive Medicaid for free up to 300% of FPL.
- Parents pay $50/month from 185%-300% of FPL.
- Childless adults pay 2% of income from 185-250% of FPL, and then 3% of income from 250-300% of FPL.
- All individuals can buy-into Charter Oak for 4% of income from 300-350% of FPL, and 5% of income from 350-400% of FPL.

HealthFirst Proposal Details

- Individuals who are offered insurance by their employer (at least 50% employer share) are not allowed to take advantage of the new public insurance entitlement.
- Federal matching is assumed up to 300% of FPL but not beyond, at a rate of 50%, which may rise in the future.
- Small firms can “buy-in” to state employees plan
- In some runs, there is a mandate on individuals
- In some runs, individuals can also “buy-in” to the state employees plan.

Results: Base Run

- Results are laid out in Table 1
- First column presents ex-ante distribution of insurance
- Second column: base run, no mandate
  - 110,000 increase in public insurance – more than 25%
  - But large “crowd-out” of ESI
  - Modest movement to state employee pool from firm buy-in
  - Net reduction in uninsured of 55,000, or about 13.5% of baseline

Results: Base Run (II)

- Baseline policy costs state $290 million in 2012
  - Small offsetting rise in tax revenues
  - Net cost to state of $275 million
  - Ten year net cost of $3.3 billion
- Implications for federal government
  - Medicaid costs up, but tax revenues up as well
  - Net cost of $125 million 2012

Results: Individual Buy-In

- Now add ability of individuals to buy into state employees pool
- This has no direct cost to the state, since buy in at full price
- But has indirect cost because only the sickest buy in – so raises the cost of state employees insurance

Results: Individual Buy-In (II)

- This leads to larger erosion in ESI because sickest individuals leave
- State employee pool raises by 50% of original size
- Reduction in uninsured falls to 35,000, or less than 10%
- Medicaid costs to state down, but large rise in cost of state employees plan
- Net cost to state is $425 million in 2012, and almost $5 billion over ten years

Add Individual Mandate

- Next two columns show impact of adding individual mandate – profound effects
- Lowers number of uninsured by 90%
  - Expansion in ESI as well as larger rise in Medicaid
- Costs rise considerably
  - $690 million in increased public sector spending
  - Consistent with $1 billion cost in MA for one-third more uninsured
  - $8.3 billion over ten years

Add Individual Mandate (II)

- Mandate is clearly cost effective
  - Ten year cost is 2.5 times as large as base run
  - But covers 7 times as many people!
- Buy-in adds value with a mandate
  - Attracts 5000 more uninsured
  - Because not just the sick signing up!