Cost and Coverage Estimates for the "Healthy Americans Act"

Staff Working Paper

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Table of Contents

About The Lewin Group

The Lewin Group is a management consulting firm with a specialty in Health Care. The firm has 20 years of experience in estimating the impact of major health reform proposals. The Lewin Group is committed to providing independent, objective and non-partisan analyses of policy proposals. In keeping with our tradition of objectivity, the Lewin Group is not an advocate for this or any other health reform proposal.

Executive Summary and Introduction

The "Healthy Americans Act" (HAA) establishes a centrally financed system of private health insurance for all Americans except those covered through Medicare or the military. Participants would chose from a selection of private plans offered through newly created regional purchasing organizations called "Health Help Agencies" (HHA's). All Americans would have coverage at least as comprehensive as the health coverage now provided to members of Congress and federal workers, although an actuarially equivalent substitution of HMO and Health Savings Account (HSA) plans is permitted.

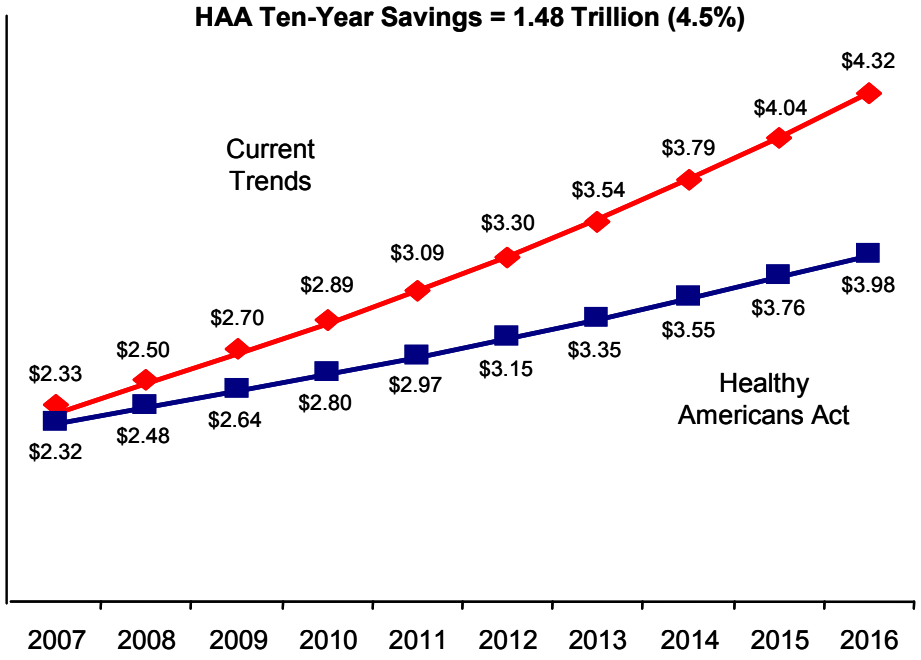
Employers would be required to "cash-out" their health plans by terminating their existing health coverage and paying the amount saved to their workers in the form of increased wages. The current tax exemption for employer provided health benefits is eliminated to strengthen incentives for families to seek lower cost coverage. However, a new "health premium" tax deduction is created so that these wage increases do not increase federal personal income tax payments. To maintain incentives to control costs, the deduction is fixed and can not be increased by purchasing more costly coverage.

All HAA participants would pay premiums through their annual income tax filings. The program would fully subsidize the premium for those below 100 percent of the federal poverty level (FPL), with the premium phasing-in for people living between 100 percent and 400 percent of the FPL. People who do not have enough income to pay taxes are assumed to be eligible for the program with full subsidies, thus eliminating the need to apply separately for assistance as under the current Medicaid program. Employers also would be required to pay an assessment ranging from 2 to 25 percent of the national average premium for the minimum benefits package, depending upon firm size and revenues per worker.

We reviewed the cost and coverage impacts of the Act. Our key findings include:

- The program would cover 246.8 million people. Over 99 percent of Americans would have coverage;
- National health spending, projected to be $2.3 trillion in 2007, would actually decline by $4.5 billion despite the expansion in private coverage, due to savings in administration ($29.8) and increased price competition for insurance ($54.9);
- The annual rate of growth in national health spending would be reduced by about 0.86 percent. Savings over the 2007-2016 period would be $1.48 trillion, which is 4.5 percent of spending over this ten-year period (***Figure ES-1***);
- All new federal program costs, $812.9 billion, are fully funded with:
  - — $516.9 billion in premium payments net of subsidies;
  - — Employer assessment revenues of $89.3 billion;
  - — State and federal share of savings to Medicaid of $153.5 billion;
  - — Reduced disproportionate share hospital (DSH) payments of $18.8 billion;
  - — Increased Social Security tax revenues less offsets of $13.1 billion; and

Figure ES-1
Change in health Spending over the 2007 Through 2016 Period



— Elimination of selected business tax credits ($22.9 billion).

- State and local Government safety-net program savings of $22.4 billion;
- Employer health spending falls by $309.8 billion (from $428.8 billion to $107.2 billion). This amount will passed-on to workers as wage increases under the cash-out; and
- Overall, increases in family premium payments are offset by the increase in wages and subsidies provided under the plan.

Key features of the Act include:

- People are never "dropped" from coverage regardless of changes in employment, income or marital status.
- The program provides incentives for consumers to demand lower-cost health coverage to control cost growth. This is because:
  - — Employer spending for health benefits is paid as wages so that the worker faces the full cost of insurance;
  - — The tax exclusion for employer provided health benefits is eliminated; and
  - — People must pay the full increment of premium for enrolling in a more costly plan.
- Administration is streamlined by:

  - — Organizing plan selection through HHAs, with employers administering annual open enrollment for their workers;
  - — There is no income-testing at the point of enrollment as under Medicaid;
  - — There are no changes in coverage due to job change or changes in family status.
- All would be enrolled in a private health plan which would:
  - — Eliminate cost-shifting for Medicaid underpayments; and
  - — Improve access for those now covered under Medicaid.
- People can enroll in an HHA plan regardless of the amount of the premium they pay, if any;
  - — People need only establish their residency to enroll in an HHA plan;
  - — No evidence of paying the premium (i.e., through tax filings) is required at enrollment; and
  - — The stigma of applying for assistance, as under Medicaid, is eliminated.

We present our financial analysis of the Plan in the following sections:

- The Healthy Americans Act;
- The impact of the HAA on National Health Spending
- Federal spending under the HAA
- Impact on state and local governments;
- Private employer impacts; and
- Impacts on family health spending.

A. The Healthy Americans Act (HAA)

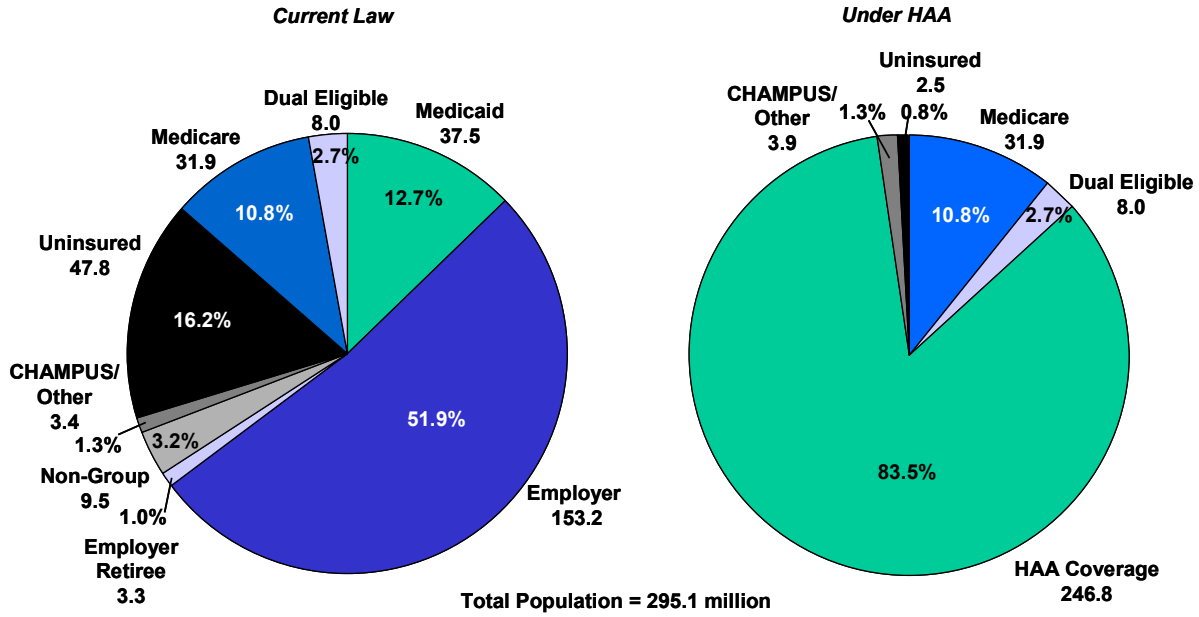
Under the Healthy Americans Act (HAA), all Americans except those covered through Medicare or the military would chose from a selection of private plans offered through newly created regional purchasing organizations called "Health Help Agencies" (HHA's). Employers would cancel their current health plans and would be required to pay the amounts saved to workers in the form of increased wages. Participants would then pay the full amount of the premium for the plan they select, which would be subsidized on a sliding scale with income for those living below 400 percent of the federal poverty level (FPL). Premiums would be collected through the personal income tax system to simplify premium collections and administration of premium subsidies.

For illustrative purposes, we have assumed that the program will be fully implemented in 2007. The major features of the plan are described below.

1. Coverage

The program would cover 246.8 million people (75.8 million children and 171.3 million adults), including those now eligible for Medicaid (***Figure 1***). This excludes the Medicare and military dependents population. It includes those who currently have private insurance, Medicaid and the Medicaid population. Over 99 percent of Americans would have coverage.

Figure 1
US Population by Primary Source of Insurance, Under Current Law and the HAA in 2007



a/ Average monthly primary payer is determined on basis of prevailing coordination of benefits practices now in use.
Source: Lewin Group estimates using the Health Benefits simulation Model (HBSM).

All families would choose from a selection of health plans offered through regional purchasing organizations called "Health Help Agencies" (HHAs). People are required to have a benefits package that is at least as comprehensive as the Blue Cross/Blue Shield (BCBS) standard option plan offered through the Federal Employees Health Benefits Program (FEHBP), which is summarized in ***Figure 2***.

Figure 2
Federal employee Health Benefits Plan (FEHBP), Blue Cross/Blue Shield Standard Benefit Option

Service	Cost Share
Adult preventive screenings and office visits	$15 office visit co-payment; none for covered preventive screening
Child preventive care	None for covered services
Inpatient services	$250 yearly deductible
Home and office visits	$15 office visit co-payment
Outpatient physical, occupational, and speech therapy	$15 for each visit 75 visit maximum per year
Mail service pharmacy	Up to a 90-day supply $10 co-payment for generic drugs $35 co-payment for brand name drugs
Retail pharmacy	Up to a 90-day supply 25% PPA at the time of purchase
Hospital inpatient	$100 per admission co-payment
Outpatient facility care, excluding laboratory and x-ray services	Subject to $250 calendar year deductible
Outpatient surgery	10% PPA
Accident Injury – emergency room care and ambulance services	None for covered charges for services rendered within 72 hours of the accident
Medical emergency – facility care	Subject to $250 calendar year deductible 10% PPA
Medical emergency – physician care	$15 office visit co-payment
Outpatient professional services	$15 office visit co-payment
Spinal manipulations	Up to 10 spinal manipulations per year $15 co-payment
Routine dental care	Benefits paid according to yearly fee schedule
Catastrophic benefits	100% payment level begins after you pay $4,000 out-of-pocket in coinsurance, co-payment and deductible expenses

Participating health plans are required to offer the minimum benefits package but may offer more comprehensive coverage alternatives as an added cost option. Carriers would also be able to offer HMOs and HSA plans, provided they are at least actuarially equivalent to the minimum

standard benefits package.[1] We estimate that the national average premium for those under the HAA in 2007 would be as shown in ***Figure 3***.

Figure 3
Estimated National Average Premium for the BCBS Standard Option Plan for 2007

	Monthly Premium	Annual Premiums
Single	$357	$4,284
Married (Joint filers with no dependents)	$714	$8, 568
Two Parent Families (Joint filers with dependent children)	$883	$10,546
One Parent Families (Head of household)	$663	$7,956

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

Health plans would compete on the basis of price. Plans with premiums below the regional average would be available to people with no additional premium requirement. However, people who enroll in one of the more costly and/or comprehensive plans would be required to pay the full incremental cost of doing so. This is designed to provide incentives for people to enroll in the less costly plans. Participants would never be "dropped," although people would be able to change their source of coverage during an annual open-enrollment period.

Employers would administer the selection of health plans for workers just as many employers do now. This would be done using informational materials supplied by the local HHA. This is designed for the convenience of the worker and to maintain a sense of continuity as the nation shifts to the new health insurance model. In cases where the worker chooses a plan requiring additional premium payments from the individual, the employer would facilitate these additional premium payments through withholding. Non-workers would select their health plan directly through the HHA. People who do not voluntarily select a plan would be randomly assigned to one of the plans with premiums below the regional average.

2. Premium Payments

People would pay premiums for the plan they select through the tax system. Premiums for each individual and/or family would be computed as an add-on to their tax liability. Premiums would be subsidized for people living below 400 percent of the FPL. People living below 100 percent of the FPL would pay no premium. The premium is then phased-in on a sliding scale with income between 100 percent and 400 percent of the FPL. People living above 400 percent of the FPL would pay the full premium. The subsidy would be provided for only the minimum

[1] For example, an HSA could be offered with a high deductible with the difference in actuarial value would be placed in the individual's account.

benefits package up to the average premium in their area for that coverage. The following apply to the determination of premiums for tax filers:

- The premium the individual pays is equal to the premium for the plan they have chosen up to the average premium for the minimum benefits package in their area;
- Separate premiums would be set for individuals, married couples, head-of-household and family coverage;
- Premiums are community rated within each area, meaning that premiums do not vary with age, gender, experience or health status. However a discount is allowed for people participating in a wellness program;
- Tax filers are assumed to be responsible for premiums for all of those for whom a personal exemption is taken, including spouses and dependent children; and
- Any additional premium owed for enrolling in a more costly and/or more comprehensive plan would be paid through employer withholding or direct payments from the individual.

Federal withholding tables would be modified to reflect the cost of their health plan, up to the average premium for the minimum benefits package in the area. Workers may adjust withholding to better reflect their expected payments as under current tax law.

3. Health Help Agency (HHA) Responsibilities

The HHAs are charged with administering the selection of health plans to serve in each area. They are also responsible for enrolling people in the plans chosen, and the distribution of premiums collected through the federal tax system to the appropriate health plans. The regional HHA would perform the following functions:

- Administer the process of soliciting and approving bids to offer insurance;
- Develop criteria for health plan participation such as adequacy of network, reserves, quality standards and customer satisfaction;
- Provide materials to be used by people in selecting health plans;
- Process plan assignment based upon selections reported by employers and as submitted to the HHA by non-workers (i.e., non-workers would select their plan directly through the HHA on-line or in person);
- Arrange for premium payments to individual health plans using premium revenues allocated from federal tax collections and subsidy payments;
- Administer a risk adjustment methodology to account for differences in enrollees by age and other risk factors; and
- Establish consumer access vehicles by doing the following
  - — Maintain a toll-free "Help" line for consumer/employer questions; and
  - — Enable "on-line" plan selection system.

The HHA would prepare an enrollment list of people covered under each of the plans selected. They would then transfer that list and the appropriate amount of premiums directly to these plans in a single monthly lump-sum payment. This approach reduces administrative costs by achieving economies of scale in enrollment and premium payments and eliminates broker and agent commissions. The impact of this on insurer administrative costs is discussed below.

However, the HHAs would require funding to perform these functions. We estimate that HHA costs would be equal to about 3.2 percent of claims. This estimate is based upon data from the Health Insurance Purchasing Cooperative (HIPC) for small employers (i.e., less than 50 workers) in California, which performs a similar roll in administering plan selection and premium payment. The HIPC, reports that their administrative costs are covered through a premium add-on of about 4.5 percent. We adjusted this add-on percentage to reflect that HHAs would be compiling plan selection information submitted by employers of all sizes, including very large employer plans where there will be substantial economies of scale.

4. Employer Responsibility

Employers are required to "cash out" their health plans. This means that employers would discontinue their health plans for those covered under the HAA and give the amounts saved to workers in the form of increased wages. The cash-out would apply to both workers and non-Medicare retirees (i.e., early retires). This effectively converts employer coverage to a defined contribution model for those now offering insurance. As discussed below, a new health premium deduction is created so that personal income tax revenues are not increased by this increase in wage income (i.e., before including the premium payment).

All employers are required to pay a fee equal to between 2 and 25 percent of the regional average premium amount for the minimum benefits package. Businesses with 50 or fewer FTE employees would pay between 2 percent and 10 percent of the national average premium per full-time-equivalent (FTE) worker ***(Figure 4)***. For each FTE employee in firms with 51 to 200 employees, the rate paid would increase by 0.1 Percent. All businesses with 200 or more FTE employees would pay 17 percent to 25 percent of the average premium. Non-profits, state and local governments, and enterprises which have no revenues for the previous tax year would pay at the 2 Percent to 17 percent rates. This is designed to minimize the effects on the labor market and to avoid abrupt changes in costs per worker that could affect hiring. The FTE measure has the effect of reducing the fee payment for part-time workers.

Also, all employers, including those who do not currently offer insurance, are required to perform the following administrative functions:

- Administer the selection of health plans for their workers during the open enrollment period using materials supplied by Health Help;
- Administer withholding for the amount of the lowest cost premium in the area through the income tax; and
- Administer supplemental withholding for workers who select a plan requiring an additional premium.

Figure 4
Employer Assessment Rate by Number of FTE Employees and Firm Revenues Per Employee [a/]

Revenue Per FTE Employee	Less than 50 FTE Employees	Over 200 FTE Employees
Less than $18,000	2%	17%
$18,000-$35,000	4%	19%
$35,000-$75,000	6%	21%
$75,000-$220,000	8%	23%
$220,000 or more	10%	25%

a/ For each FTE employee in firms with 51 to 200 employees, the rate paid would increase by 0.1 percent.

The employer's role is intended to give workers the convenience of selecting a plan through work and reduces HHA costs.

5. Insurer Responsibility

Insurers would be responsible for establishing provider networks and processing all claims as under the current system. However all enrollment functions would be performed through the HHAs based upon consumer plan selections. For each insurer, the HHAs would compile an enrollment list of people from around the region who have elected to enroll in the plans based upon results of the open enrollment period, most of which would be administered through employers. The HHAs also make all premium payments to the plans that people have selected.

This approach greatly reduces the administrative costs now incurred by insurers under the current system. Insurance broker and agent fees for health insurance would be eliminated, as would medical underwriting costs. It also reduces premium collection costs by obtaining payment from a single source (i.e., the HHA) for all of those that they insure. Insurers would continue to perform the following functions:

- Claims processing;
- Network development;
- Disease management and other innovations;
- Marketing during open enrollment; and
- Internal administrative functions such as payroll, supplies, facilities and other general administrative functions.

In this analysis, we assumed that administrative costs and profits for insurers would be comparable to those of large employer groups in today's system (i.e., 3.4 percent of claims costs). Administration and profit for private insurance ranges from about 3.4 percent of claims for large groups (i.e., 10,000 or more workers) to 30 percent or more for individuals and very

small employer groups.[2] This reflects economies of scale in providing coverage to a large group rather than through many small groups.

The HHAs would effectively organize regional populations into a large single group for each insurer, each of which is likely to include 10,000 or more members. Thus, by using the HHAs as a single source for enrollment and premium payments, insurers can be expected to cover these populations at costs comparable to those of existing large groups.

It is important to recognize that insurers would be at-risk for losses in excess of premium revenues. This loss exposure would maintain existing incentives for insurers to establish the most efficient provider networks possible. However, insurers would need to be compensated for accepting this risk exposure or else none would participate. We have assumed profit equal to 1.1 percent of covered services. We assume the following costs for participating insurers expressed as a percentage of claims costs:

- Claims Administrations: 3.0 percent;
- General Administration: 0.7 percent;
- Interest Credit: -1.5 percent;
- Risk and Profit: 1.1 percent; and
- Marketing: 0.1 percent.

6. Federal Taxes

This Internal Revenue Services (IRS) would administer premium collections and subsidy allowances for the minimum benefits package. The tax forms would be modified to include a worksheet to calculate the insurance premium each filer must pay. As discussed above, the premium would be based upon the premium for the minimum benefits package for the plan they have selected, up to the average premium for this benefits package in their area. Premiums would vary for: single filers, joint filers without children, joint filers with children and single parents with children (see ***Figure 3*** above).

The worksheet would include calculation of the subsidy amount for each filer. As discussed above, people living below the FPL would not pay a premium, with the premium phased-in between 100 percent and 400 percent of the FPL. The amount owed by the tax filer would be the premium less the amount of the subsidy. Withholding forms would be adjusted so workers withhold the appropriate amounts.

The Act eliminates the tax exclusion for employer provided health benefits by requiring employers to "cash out" their plans in the form of higher taxable wages. However, the tax code is modified so that the increased wage income from the "cash out" does not result in an increase

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[2] Estimates are based upon underwriting practices of major insurance companies. Hay/Huggins Company, Inc. As appeared in: "Cost and Effects of Extending Health Insurance Coverage" Congressional Research Service (CRS), October 1988.

in personal income tax revenues. This is done by creating a new health premium deduction to compensate for that effect. The deduction is computed as follows:

- Tax deduction equal to National average premium amount + 43.5%;
- Additional Family Tax Deduction of $2,000 per Child;
- Tax Deductions Phased In for Families Between 100% and 400% of FPL (i.e., full deduction for families over 400% FPL); and
- Tax deductions phased out for families between $125,000 and $250,000 (i.e., no deduction over $250,000).

The deduction amount is an "above the line" adjustment used in determining the amount of adjusted gross income (AGI) for each filer. Because in most states AGI is the basis for calculating state income taxes, the deduction will avert most increases in state income tax revenues resulting from the "cash out".

It is important to understand that the amount of the deduction is a fixed dollar amount, regardless of the premium for the plan they are actually enrolled in. This means that individuals are not able to increase their deduction by adopting a more costly health plan. This is essential to maintaining incentives for individuals to seek out lower cost alternatives. The amount of the deduction is indexed annually to the growth in the Consumer Price Index.

We assume that the administrative budget for the Internal Revenue Service (IRS), currently about $9.0 billion, is increased by 25 percent to process to administer and audit the premium and subsidy computation components of the program. This would be an additional $2.2 billion in the IRS administrative budget. As discussed below, there would be no need to verify coverage status as part of the process of paying premiums, which would reduce the cost of administering premium collections.

7. Enforcing the Coverage Mandate

Although the program establishes a mandate for people to have insurance coverage, it would not require people to show proof of coverage when they file their tax returns. The reason for this is that people can not avoid paying the premium by failing to enroll in a plan. People must pay the premium though their taxes, regardless of whether they have enrolled in a plan. Existing enforcement mechanisms for tax compliance would be all that is needed to enforce premium collections.

Because payment of premium is enforced, there is no reason for an individual not to take coverage. Also, the system is designed so that once people do enroll in a plan, they are never dropped from coverage until they die, move or age into Medicare. Thus, once an individual accesses the health care system, they would not leave the system, even if they managed to avoid paying a premium. Consequently, people would not need to show proof of coverage to the IRS or any other agency. Also, no penalties or fines are required. These features greatly reduce the cost of administering the program.

B. The Impact of the HAA on National Health Spending

The Office of the Actuary for the Center for Medicare and Medicaid Services (CMS) projects that total health spending will increase to $2.3 trillion by 2007. This includes all spending for health services including the amounts paid by government programs, private insurance and out-of-pocket by families. It also includes the cost of administering insurance and government programs which is projected to be $170.3 billion in 2007.

We estimate that national health spending would actually decline by $4.5 billion despite the expansion in private coverage ***(Figure 5).*** This is because the increase in health services use by newly insured people would be offset by savings in administration ($29.8) and increased price competition in the insurance industry ($54.9).

Figure 5
Changes in National Health Spending under the HAA in 2007 (in billions)

Net Change in Spending for Health Services		**($1.2)**
Change in utilization for newly insured	$49.0	
Change in utilization due to improved coverage	$4.7	
Consumer incentives and Insurer price competition	($54.9)	
Reimbursement Effects		**$26.5**
Change in Provider Income less Reduce Cost-Shift		
Payments for formerly uncompensated care	$15.9	
Use of commercial payment rates for all in program	$46.5	
Eliminate Disproportionate Share Hospital (DSH) Payments		
Medicare	($9.5)	
Medicaid	($8.8)	
Reduced cost shifting (assumes 40 percent passed to Payers)	($17.6)	
Net Change in Administrative Costs		**($29.8)**
Insured administration	($56.9)	
Health Help Agency administration	$24.9	
Administration of subsidies	$2.2	
Total Change in Health Spending		**($4.5)**

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

1. Health Expenditures for Newly Insured

We estimate that currently uninsured people would increase their utilization of health services by about $49.0 billion once they become insured. This estimate is based upon our assumption that the utilization of health services by newly insured people would on average adjust to the levels reported by insured people with similar age, gender, and health status characteristics.

In addition, we estimate an increase in utilization of health services for currently insured people who become covered for additional services as a result of the minimum benefits package. These include primarily outpatient prescription drugs and dental services for people who were not covered for these services under their current plan. We assume that people who are newly covered for these items would increase their utilization to the levels reported for these services by people who were covered by these services, adjusted for age, gender and health status. The cost of these additional services would be about $4.7 billon.

2. Savings from Incentives and Price Competition

We estimate that the incentives for price competition created under the program would save about $59.4 billion. The program includes features designed to make people more aware of their spending for health care and to create incentives for consumers to seek-out lower-cost health coverage. One of these features is that employer spending for health benefits converted to wages so that the worker faces the full cost of health insurance. This would give families the opportunity to retain some of this cash for other purposes by purchasing a less costly health plan. Also, families must pay the full amount of the added cost of selecting a higher cost health plan as further incentive to conserve on spending.

Another major feature of the plan is that it eliminates the tax exclusion for employer provided health benefits. Under current law, the amount of the employer's contribution for a worker's health benefits is not taxed as a source of income to the worker. This has the effect of subsidizing the purchase of health coverage. Many economists believe that this fuels the demand for highly comprehensive health plans that encourage increased utilization of health services.

We estimated the savings from these changes in incentives assuming that the program has the effect of moving people to lower cost organized systems of care such as HMOs. We assume that making people face the full cost of their coverage without tax subsidies has the effect of increasing their perceived cost of coverage. We assumed that this increase in price was equal to the amount of the tax subsidy lost by eliminating the tax exclusion.

We modeled the number of people shifting to HMOs based upon research on the effect that increases in price for a given insurance product have on the likelihood of moving to an alternative lower-cost health plan.[3] We assumed that savings would be about twelve percent for people who move to an HMO, which is based upon other research indicating that HMO costs are about 12 percent lower than in fee-for-services models such as Preferred Provider organizations (PPO).[4]

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[3] On average, a one percent increase in the price of an insurance product causes about 2.5 percent of members to shift to lower cost products. No savings are calculated for people currently in HMOs. Source: Stombom, B.,Buchmueller, T.,Feldstein, P. "Switching costs, Price Sensitivity and Health Plan Choice", *Journal of Health Economics* 21 (2002) 89-116

[4] Stapleton, D., "New Evidence on Savings from Network Models of Managed Care," (a report to the Healthcare Leadership Council), The Lewin Group, Washington, DC, May 1994.

Using these assumptions, we estimate a reduction in health spending for those shifting to lower cost plans of about $54.9 billion. These are savings of about 6.7 percent for those who would be covered under the program.

3. Reimbursement Effects

In addition to changing the levels of health services utilization, the HHA would have a significant impact on provider reimbursement levels. Under the Act, all participants would be covered under private health insurance plans, including the non-Medicare population currently covered under Medicaid. This would increase income to providers because commercial provider payment rates can be up to twice what is paid under Medicaid for the same service. We estimate that the increase in provider compensation would increase health spending by about $46.5 billion in 2007.

In addition, there would be a reduction in uncompensated care of about $15.9 billion as the uninsured become covered under the program. This would take the form of increased provider reimbursement in that providers would now be paid for services that were provided without payment under current law. These reimbursement increases would be partially offset by reductions in disproportionate share hospital (DSH) payments under Medicare and Medicaid ($18.8 billion).

Some of these increases in reimbursement will be passed back to payers in the form of reduced payments for services provided. In today's system, shortfalls in reimbursement for the uninsured and Medicaid services are shifted to private payers through increased charges, which is a process known as "cost-shifting". Thus, private payer rates include a cost shift component to make-up for shortfalls in payment under government programs and the uninsured. Increasing payments for those now covered under Medicaid should reduce this cost-shift.

There are two separate studies indicating that about half of hospital payment shortfalls are passed-on to private payers in the form of higher charges.[5] However, two other studies showed considerably less evidence of hospital cost-shifting, although they did not rule out a partial cost-shift.[6] One study of physician pricing by Thomas Rice et al., showed that for every one percent reduction in physician payments under public programs, private sector prices increased by 0.4 percent.[7] Our own analysis of hospital data indicated that about 40 percent of the increase in

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

6 Zuckerman, Stephen, "Commercial Insurers and All-Payer Regulation," *Journal of Health Economics*, Vol. 6. No. 2 (September 1987); and Hadley, Jack and Feder, Judy, "Hospital Cost Shifting and Care for the Uninsured." *Health Affairs*, Vol. 4 No. 3 (Fall 1985).

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

hospital payment shortfalls (i.e., revenues minus costs) in public programs were passed-on to private-payers in the form of the cost shift during the years studied.[8]

Based upon this research, we estimate that 40 percent of these increases in reimbursement would be passed back to payers in the form of reduced charges. Thus, there would be cost-shifting savings of about $17.6 billion. This would leave a net increase in provider reimbursement of $26.5 billion.

4. Insurer Administration

The CMS projects that total spending for administration of private insurance and public programs will reach about $170.3 billion in 2007. This estimate includes both the cost of administration and insurer profits. In fact, administrative costs are projected to grow faster than health services costs.

We estimate that the HAA would reduce insurance administration by $29.8 billion. Administrative costs for private insurers would fall by $56.9 billion. These savings would be partly offset by the cost of administering plan selection through HHAs ($24.9 billion) and the cost of administering premium collections through the tax system ($2.2 billion).

Much of these savings are achieved by extending large group economies of scale throughout the health insurance system. Rather than corresponding with thousands of individual small groups, the HHAs would assemble the list of people in the region who have elected to enroll in their plan(s), which will generally include 10,000 or more members at a time. This relieves the insurer of the cost of dealing separately with many groups. It also limits insurer risk because costs can be predicted more reliably for larger groups, which can influence insurer pricing. Administrative costs, for groups of 10,000 or more workers are typically equal to about 3.4 percent of claims, while administrative costs for individuals and very small groups can be 30 percent or more of medical costs.

The HHAs would be responsible for administering the enrollment functions now performed by agents, brokers and insurers. However, the Act eliminates the cost of broker and agent commissions, premium collections and medical underwriting. Other sources of administrative savings include:

- The minimum benefits package will standardize basic benefits;
- Changes in coverage due to job change or changes in family status are eliminated;
- The cost of income-testing at the point of enrollment under Medicaid is eliminated (except for people seeing supplemental benefits); and

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[8] Sheils, J., Claxton, G., "Potential Cost Shifting Under Proposed Funding Reductions for Medicare and Medicaid: The Budget Reconciliation Act of 1995," (Report to the National Coalition on Health Care), The Lewin Group, December 6, 1995

- Withholding for premiums automatically terminates while unemployed, thus eliminating the need to apply separately to an agency to obtain assistance in paying the premium.

C. Federal Spending under the HAA

The HAA program is fully funded. Total federal spending under the program would be about $812.9 billion ***(Figure 6)***. This would be offset by about $814.4 billion in: premium revenues, savings to other programs, and eliminating certain business tax credits described below.

Figure 6
Federal Expenditures under HAA in 2007 (in billions)

Uses of Funds		Sources of Funds	
Program Benefits Costs	$759.4	Household Premiums (net of subsidies $293.8)	$516.9
Insurer Administration and Profit	$26.4	Employer Premium Payments	$89.3
Health Help Agency	$24.9	Federal Medicaid Savings	$82.9
Administration of premium collections and subsidies through taxes	$2.2	State Maintenance of Effort	$70.6
		Medicaid & Medicare DSH	$18.8
		FEHBP Workers & Dependents $14.7 Retirees $2.3 Wage Effects ($17.0)	$0.0
		Personal Income Taxes Tax on wage cash-out $96.2 Deduction for Health ($147.7)	($51.5)
		Social Security and HI taxes	$64.6
		Eliminate Certain Business Tax Credits	$22.9
		Total Offsets	**$814.4**
		Additional Funding Required	($1.5)
Total Program Costs	**$812.9**	**Total Funding**	**$812.9**

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

1. Program Costs

The cost of benefits for those covered under the program would be $759.4 billion in 2007. Insurer administrative costs for this population would be $26.4 billion. HHA administrative costs would be $24.9 billion and the cost of administering premium collections and disbursements through the tax system would be $2.2 billion. Total administrative costs for the program would equal about 6.6 percent of total program spending.

2. Funding Provisions

Total premium revenues from individuals and employers would be about $606.2 billion. The program would collect $516.9 billion in premiums from participants, net of subsidies for those living below 400 percent of the FPL. Employer premium payments would be $89.3 billion.

Savings to Medicaid for people who become covered under the HAA would be recovered and used to fund the program. The federal share of savings for this population would be $82.9 billion. States would be required to make maintenance-of-effort (MOE) payments to the program equal to the amount of their savings, which would be $70.6 billion in 2007. The Medicaid program would remain unchanged for those who do not become covered under the HAA program. Also, HAA covered people who meet the current program eligibility criteria would be able to apply to the Medicaid program to obtain coverage for benefits and cost-sharing that is not covered under the HAA minimum benefits plan.

Disproportionate share hospital (DSH) payments would be nearly eliminated. DSH payments are intended to supplement Medicaid payments, which are typically below costs, for hospitals serving a disproportionate share of Medicaid patients. These payments would no longer be needed once the Medicaid population is moved to private coverage with commercial payment levels as under the HAA. Under the act, Medicare DSH payments are eliminated. Also, all but about $1.0 billion of Medicaid DSH payments would be eliminated. Total savings would be $18.8 billion.

The federal government would also "cash out" its Federal Employee Health Benefits Program for workers and non-Medicare retirees, with no net change in federal spending.

3. Tax Effects

Personal income tax revenues would fall by $51.5 billion in 2007. The increased taxes that would have been paid on wages from the "cash out" ($96.2 billion) would be more than offset by the revenue reduction attributable to the newly created health premium deduction ($147.7 billion). There would be an increase in Social Security and Medicare HI tax revenues of $64.6 billion, including the employer and the employee shares.

The HAA also includes provisions that would eliminate certain tax preferences including:[9]

- Voluntary Employees' Beneficial Associations (VEBAs) are associations of employees who have common employers that are set up to provide medical, disability and other benefits to their members. If certain requirements are met, VEBAs' income is exempt from Federal taxes ($17.6 billion over 5 years);
- The inventory property sales source rule exception creates a special rule for exports sales of inventory that allows up to 50 percent of the combined income of U.S. companies from export manufacture and sale to be exempted from U.S. taxes ($33 billion over 5 years);

[9] Estimate provided by the Joint Committee on Taxation (JCT).

- The production activity deduction allows a deduction for property manufactured, produced, grown or extracted in the US to lower the effective tax rate on exports ($34 billion over 5 years); and
- The deferral of active income of controlled foreign corporations allows US companies to defer taxes on the income of controlled foreign subsidiaries until the income is repatriated to the US ($30.1 billion over 5 years).

D. Impact on State and Local Governments

The program would result in savings to state and local governments of about $22.4 billion in 2007 ***(Figure 7)***. These include savings to safety-net providers that currently provide free care to the uninsured of $20.1 billion and an increase in state income tax revenues due to the employer "cash out" of health benefits.

Many state and local governments fund public hospitals and clinics to provide services to low-income uninsured people. Under the HAA, nearly all of the uninsured people that these providers treat would become insured. Thus, the amount of subsidy they require by safety-net providers from state and local governments would be reduced.

Figure 7
Change in Health Spending for State and Local governments Under the HAA in 2007
(billions)

	Change in Spending
Program Costs/(Savings) Federal AGI amount	
Savings to Safety-net and Other Programs	($20.1)
State and Local Workers Health Benefits	$0.0
Workers and Dependents ($57.7)	
Retirees ($6.3)	
Wage Cash-out $64.0	
Medicaid Program Savings	$0.0
Program Savings ($70.6)	
Maintenance of Effort $70.6	
Increased Tax Revenue from Premium Cash Out [a/]	$2.3
Total Costs (Savings)	**($22.4)**

a/ About 85 percent of States currently base state income taxes on the amount of the filer's adjusted gross income (AGI) amount as determined on the federal form, which under the HAA would reflect the new health premium deduction. Therefore, the increases in wages due to the cash-out generally would not result in an increase in state income taxes.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

State government spending for Medicaid would decline by about $70.6 billion. This is the state share of savings from covering all of the non-Medicare Medicaid-eligible population (i.e., children, parents etc.) under the HAA. The Medicaid program would be unchanged for those who are not covered under the HAA (i.e., Medicare eligible people and Military dependents). Also, we assume that HAA covered people who would have been eligible for Medicaid under current law would be able to enroll in Medicaid to cover co-payments under HAA plans and Medicaid covered services that are not included in the HAA minimum benefits package.

The HAA would require states to make maintenance-of-effort (MOE) payments to the HAA program equal to the amount of the reduction in Medicaid spending under the program. This payment would be $70.6 billion in 2007. Thus, the state's share of savings to Medicaid would be exactly offset by the MOE payment.

State and local governments would also "cash out" their health plans for worker and non-Medicare retirees. Thus, the savings to state and local worker health benefits programs would be offset by the increases in wage payments.

State income tax revenues would change little due to the increase in taxes resulting from the health benefits cash-out. This is because about 85 percent of States currently base state income taxes on the amount of the filer's adjusted gross income (AGI) as determined on the federal form. Because AGI would now reflect the new health premium deduction created under the HAA, there should be little change in tax revenues except in those states that do not base their income tax on the Federal AGI amount.[10] This results in $2.3 billion in new revenues for states.

[10] Some states may need to adjust their tax code to maintain current revenues in cases where the revenue increases due to the cash-out are less than the impact of the health premium deduction.

E. Private Employer Impacts

We estimate that private employer spending for health benefits will reach $428.8 billion in 2007. This includes the total cost of health benefits less the amount of the worker's premium contribution. It also includes spending for workers and their dependents ($394.3 billion) and retirees ($34.5 billion).

Figure 8
Changes in Private Employer Health Benefits Costs by Current Insuring Status under the HAA in 2007
(billions)

	Currently Insuring Employers	Currently Non-Insuring Employers	All Employers
Private Employer Spending Under Current Policy			
Current Cost of Coverage			
Workers & Dependents	$394.3	--	$394.3
Retirees	$34.5	--	$34.5
Total Current Law	**$428.8**	--	**$428.8**
Private Employer Spending Under the HAA			
Remaining Health Benefits for Medicare Participating Members			
Workers & Dependents	**$24.3**	**--**	**$24.3**
Retirees	**$20.6**	**--**	**$20.6**
Premium Payments to Program	**$62.3**	**$11.8**	**$74.1**
Total Under HAA	**$107.2**	**$11.8**	**$119.0**
Net Change in Private Employer Spending			
Net Change Under HAA	**($321.6)**	**$11.8**	**($309.8)**

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

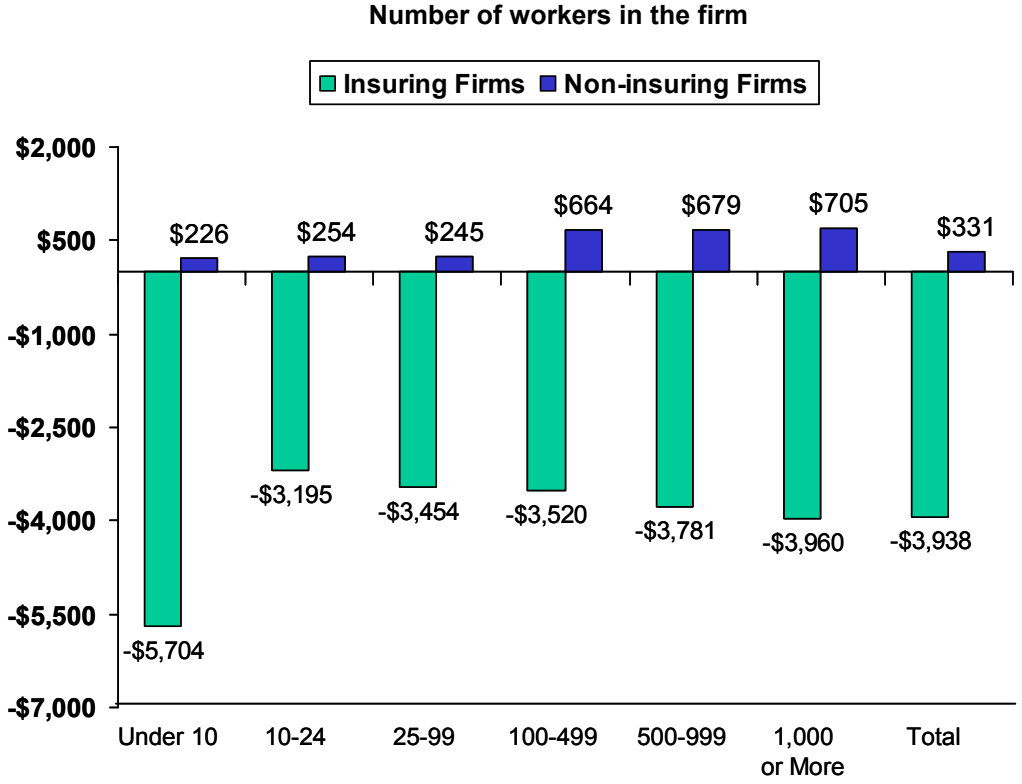
Private employer health spending under the HAA is reduced under the HAA by $309.8 billion, from $428.8 billion under current law to $119.0 billion under the program. We assume that insuring employers would continue to cover people who do not become covered under the HAA. These include primarily workers, dependents ($24.3 billion) and retirees ($20.6 billion) who are enrolled in Medicare.

As discussed above, all employers would be required to pay an assessment equal to 2 percent to 25 percent of the average premium for each FTE employee, depending upon the size of the firm and revenues per employee. For private firms that now provide coverage, the total amount of the assessment paid would be $62.3 billion. The payments for firms that do not currently offer coverage would be $11.8 billion

The amount of the reduction in health spending for private insuring firms would be about $3,938 per worker ***(Figure 9)***. For firms that do not currently provide coverage, there would be a net increase in health spending of $331 per worker. ***Figure 9*** presents estimates of the change in private employer health spending by firm size for insuring and non-insuring firms. Currently insuring firms with fewer than 10 workers would on average save more ($5,704) per worker, which is more than for any other firm size group. This is because the smaller firms that do

provide coverage tend to have higher income employees (e.g., lawyers, doctors, etc.) with more comprehensive health plans, lower worker premium contribution amounts and more dependents than in other firm size groups.

Figure 9
Change in Private Employer Health Spending by Current Insuring Status under the HAA in 2007



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

We assume that the savings to employers would be passed-back to workers in the form of increases in wages. This reflects the HAA requirement that employers "cash-out" their benefits plans. It also reflects economic theory and research indicating that changes in employer benefits for health care are, in the long run, passed back to workers in the form of wages or some other form of compensation such as pensions or disability insurance.

This reflects that the employer's true cost of employing workers includes all compensation costs including: wages less employer payroll taxes, health benefits, pensions, and other non-cash benefits. In competitive labor markets, eliminating the health benefits (or any other form of compensation) would bid-up other forms of compensation such as wages so that aggregate compensation levels are largely unchanged.[11,12]

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

F. Impact on Family Health Spending

In this analysis, we define family health spending to include the amounts paid out-of-pocket for health services plus the amounts paid by families in premiums, including the employee contribution for employer provided health benefits. As shown in ***Figure 10***, we project that under current law, family health spending will average about $3,430 per family in 2007. Family health spending varies with income from $1,350 per family with annual incomes below $10,000, to $5,760 per family for those with incomes of $250,000 or more.

Figure 10
Changes in Family Health and Spending Act in 2007

			Changes in Family Health Spending			
	Number of Families (1,000s)	Average Family Health Spending in 2007 Under Current Law [a/]	Change in Out-of-Pocket Payments for Health Services	Change in Premium Payments	After Tax Wage Effects [b/]	Average Net Change per Family Under the Act
Changes in Average Family Spending the Act by Income in 2007						
Less than $10,000	14,181	$1,348	($234)	($319)	$367	($920)
$10,000-19,999	17,987	$2,017	($70)	$40	$507	($537)
$20,000-29,999	16,685	$2,981	($71)	$939	$1,286	($418)
$30,000-39,999	13,804	$3,220	$95	$2,055	$2,321	($171)
$40,000-49,000	11,692	$3,545	$79	$3,116	$3,114	$81
$50,000-74,999	20,182	$4,190	$331	$4,593	$4,597	$327
$75,000-99,999	12,327	$4,705	$409	$5,745	$5,813	$341
$100,000-149,999	10,588	$4,875	$561	$6,115	$6,337	$339
$150,000-199,999	1,736	$5,293	$615	$6,216	$6,092	$739
$200,000-245,999	3,858	$5,647	$63	$6,685	$4,916	$1,832
$250,000 or more	2,513	$5,764	$78	$6,067	$3,915	$2,230
All Families						
Total	**125,557**	**$3,430**	**$125**	**$2,841**	**$2,988**	**($22)**

a/ Includes family premium payments and out-of-pocket spending for health services.
b/ Increase in wages resulting from the Act are counted as reductions in family health spending while decreases in wages due to the Act are treated as increase in family health spending.
Source: Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Under the HAA, family health spending would be reduced by an average of $22 per family. This reflects changes in premiums and out-of-pocket spending as well as the after tax changes in wages due to the health benefits cash-out. In this analysis, we count after-tax changes in family income under the proposal as changes in family spending for health care.

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

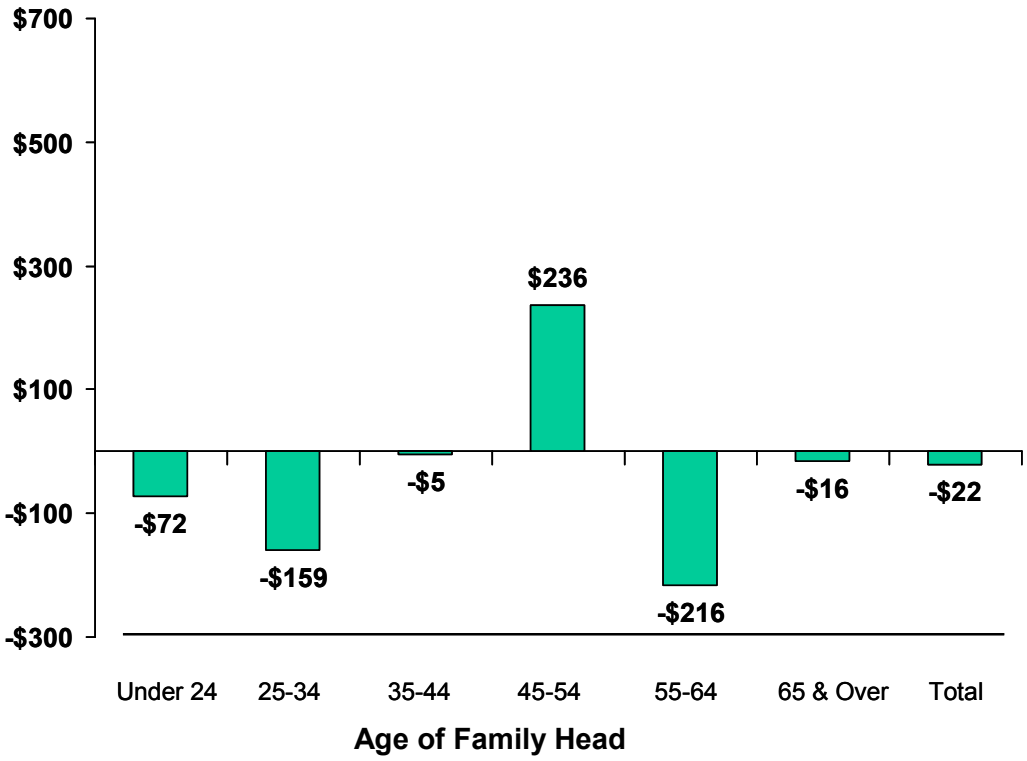
Family out-of-pocket spending for health services would increase by about $125 family. Average out-of-pocket spending would generally decline among lower income-people as previously uninsured people become insured. Out-of-pocket spending would increase as income rises, reflecting the shift of people to less comprehensive lower-cost health plans due to the incentives created under the program.

Family premium payments would increase by an average of $2,481 per family. This includes the amount of the premium for these families less the amount of subsidies provided under the Act. Premium payments decline for those with incomes of less $10,000 by about $320 per family, but increase as income increases. Average premium payments for families with incomes of $100,000 or more would increase by $6,000 or more per family living.

Family income would generally increase across all income groups due the "cash out" of employer benefits. Family income after taxes would increase by about $3,000 per family under the Act. This reflects the increase in wages from the health benefits "cash out" and all changes in taxes including the effect of the health premium tax deduction and the worker share of Social Security and Medicare HI taxes.

The average change in family health spending is presented in ***Figure 11*** by age of family head.

Figure 11
Change in Average Family Health Spending by Age of Family Head Under the HAA in 2007



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

G. Impact on Long-Term Spending Growth

As discussed above, we assume that the primary effect of the strengthened cost savings incentives under the HAA would be to increase enrollment in tightly managed systems of care such as HMOs. We estimate that enrollment in HMOs would increase from about 30 percent under current law to about 70 percent under the Act. Based upon available research, we estimate that this increase in enrollment in HMOs would result in a reduction in the long-term rate of growth in health spending.

We estimate that the annual rate of growth in health spending would be reduced by about 0.86 percent under the HAA. Total savings would be 1.48 trillion over the 2007 through 2016 period.

1. Research on Cost Growth in HMOs

There are several studies showing that increases in managed care enrollment result in a sustained, long-run reduction in the rate of growth in health spending throughout the community. For example, using California hospital cost data, Robinson has shown that the growth in hospital costs was slowed after state law changed to permit selective contracting in 1982.[13] Robinson estimated that a ten percentage point increase in HMO enrollment was associated with a 1.5 percentage point reduction in the annual rate of growth in hospital spending. Also, Zwanziger found that the growth in exclusive provider networks in California was associated with reduced hospital cost growth.[14]

Welch also showed that the growth in Medicare costs is reduced as Medicare HMO market share increases and that savings grow over time.[15] Welch's study found that a 10 percentage point increase in managed care enrollment was associated with a 1.0 percentage point reduction in the annual rate of growth in Medicare costs. Moreover, these results suggest that the price competition induced by the selective contracting practices used by managed care plans tends to reduce prices for all insured groups including those who are not covered under the managed care plans. The impact that managed care growth has had on spending for all plans in the community has been called the "spill-over effect."

The Lewin Group conducted a similar study to measure the long-term impact of increases in HMO enrollment on the rate of growth in health spending for hospital services, physicians care and prescription drugs. Our study found that as enrollment in HMOs in a community increases by 10 percent, the annual rate of growth in hospital spending is reduced by 1.3 percentage points. The study also found that a 10 percentage point increase in HMO enrollment was associated with a reduction in the rate of growth in spending for physician's services of 0.6

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[13] Robinson, J.C., "HMO Market Penetration and Hospital Cost Inflation in California," *Journal of the American Medical Association*, 266 (20 November 1991): 2719-23.

[14] Zwanziger and Melnick, "Costs and Price Competition in California Hospitals, 1980-90," *Health Affairs*, Fall 1994.

[15] Welch, W.P., "HMO Market Share and its Effect on Local Medicare Costs," HMOs and the Elderly, Health Administration Press, Ann Arbor Michigan 1994.

percent and a 0.9 percent reduction in the rate of growth in prescription drug spending.[16] These savings appear to be attributed to changes in patient utilization and price competition among providers resulting from the selective contracting practices used by managed care plans.

2. Health Spending under the HAA for 2007 – 2016

The Office of the Actuary of CMS estimates that total national health spending will increase from about $2.33 trillion in 2007 to $4.32 trillion by 2016. This is an average annual growth rate of about 6.4 percent (***Figure 12***).

Figure 12
Changes in National Health Spending Under the HAA: 2007 – 2016

	Total Spending		Savings Under HAA	Percent Savings
	Current Law	HAA		
2007	$2,326	$2,321	$5	0.0%
2008	$2,505	$2,480	$25	1.0%
2009	$2,696	$2,643	$53	1.9%
2010	$2,887	$2,804	$83	2.8%
2011	$2,868	$2,971	$116	3.7%
2012	$3,087	$3,155	$152	4.6%
2013	$3,543	$3,351	$192	5.4%
2014	$3,787	$3,552	$236	6.2%
2015	$4,044	$3,760	$283	7.0%
2016	$4,317	$3,982	$336	7.7%

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

We estimate that the HAA would slow the average annual average rate of growth in health spending by about 0.86 percent between 2007 and 2016. Total spending in 2006 would be $3.98 trillion, which is about 7.9 percent less than it would be in 2016 under current law. Total savings over 2007 – 2006 period would be about $1.48 trillion. This is a reduction in total spending over the ten years of about 4.5 percent.

[16] "Managed Care Savings for Employers and Households: 1990 through 2000", (Report to the American Association of Health Plans (AHP)), The Lewin Group, May 1997.