

Covering America

REAL REMEDIES
FOR THE UNINSURED

Cost and Coverage Analysis of Ten Proposals To Expand Health Insurance Coverage

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Appendix F

Expanding Health Insurance Coverage: A New Federal/State Approach

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The authors propose to provide states with financial incentives to establish an insurance pool that is open to state residents at all income levels. Medicaid and SCHIP eligible persons would be covered under the pool. The pool would also provide fully subsidized coverage to all persons living below 150 percent of the Federal Poverty Level (FPL) and partially subsidized coverage for persons with incomes between 150 percent and 250 percent of the FPL. Individuals at higher income levels are permitted to enroll in the plan by paying a statewide community-rated premium.

The state-wide community rate would be equal to the average expected cost of a state-determined benefits package for the non-Medicare population in the state. By charging a community rate, the pool is designed to attract persons with expected costs that are in excess of the community rate, while permitting persons with lower expected costs to obtain coverage in the private market at less than the community rate. As a result, the program effectively subsidizes the cost of coverage for higher-cost populations by an amount equal to the difference between actual costs for the enrolled population and the state-wide community rate.

Total subsidy costs under each state program would be equal to total state pool costs (benefits and administration) less premium payments received. The federal government would match state expenditures under these pools at an enhanced matching rate that is 30 percent greater than the current standard Medicaid matching rate. Program costs would be funded through increases in income taxes so that the program is progressively financed.

In this section, we summarize the key components of the authors' proposal and present our key assumptions. We then present our estimates of the impact of this proposal on coverage and costs and explore the sensitivity of our estimates to key assumptions. Our analyses are presented in the following sections:

- Proposal features;
- Key assumptions;
- Program impacts estimates; and
- Sensitivity analyses.

A. Proposal Features

1. Insurance Pools

The authors would provide incentives for states to establish statewide insurance pools that would offer free or subsidized coverage to lower income persons and community-rated coverage to the general population.

- The pools would provide fully subsidized coverage for persons currently eligible for Medicaid and SCHIP except for persons also covered under Medicare (i.e., the dual eligible population). Coverage of the non-Medicare disabled population under the state pool would be optional to the state.
- There would be a net increase in provider reimbursement for persons currently covered under Medicaid who would be shifted to one of the private plans in the state pool (private sector reimbursement levels are typically higher than in public programs on a per unit of service basis).
- The pools would also provide fully subsidized coverage for all persons living below 150 percent of the Federal Poverty Level (FPL), and partially subsidized coverage for persons with incomes between 150 percent and 250 percent of the FPL.
- All persons in the state except those covered by Medicare would have the option of taking coverage through the state pools by paying a statewide community rate.
- The community rate would be based on the average expected cost of coverage for the state-determined benefits package for all persons who are potentially eligible to enroll in the pool (i.e., the non-Medicare population). This includes the non-Medicare disabled population in states that decide to cover this group under the state pool.
- We assume that the community rate would vary with family type (i.e., single, couple, or family). Some limited variation by age also would be permitted at the state's option. Rating variation by age would be permitted subject to a +/- 50 percent rating band.
- States are encouraged to participate by increasing the federal matching rate by 30 percent for states that decide to participate. The enhanced matching rate in participating states would also apply to portions of Medicaid that would not be folded into the state pool including:
 - Long-term care;
 - EPSDT;
 - School-based therapies and other services;
 - the Medicare dual eligible population; and
 - Medicaid-eligible disabled persons in states that decide not to include this group in the state pool.
- States would be required to sponsor at least one managed fee-for-service plan. Other types of health plans also could be offered as options.

2. Subsidies

Participating states would agree to provide the following subsidies:

- Fully subsidized coverage for the Medicaid and SCHIP population that would be covered under the state pool.
- The program pays the full amount of the community-rated premium for persons with incomes below 150 percent of the FPL.
- For persons with incomes between 150 and 250 percent of the FPL, the state would pay a portion of the premium on a sliding scale with income subject to the following limits:
 - The family premium is capped at 7.0 percent of income for persons between 150 and 200 percent of the FPL.
 - The family premium is capped at 12.0 percent of income for persons between 200 and 250 percent of the FPL.
- States have the option of providing subsidies at higher levels of income, which we also assume would be matched by the federal government at the enhanced matching rate.

3. Employer Role

- Employers in participating states would have two options:
 - Employers can continue to provide coverage through private insurance including self-funded and fully-insured arrangements. However, the employer must also provide coverage through the public plan as an option so as to assure that all eligible workers would have access to premium subsidies, which are available only through the pool;
 - Employers can choose to offer coverage through the plans in the pool only.
- Employers with multiple plans are required to make equal contributions to each plan selected by workers whether it is in or out of the state pool.
- We assume that the employer contribution for a worker offsets the community-rated premium for that worker in the pool. The premium subsidy amount for lower income persons is then computed on the remainder of the community-rated premium for that individual as described above.
- There are no minimum coverage or contribution requirements for employers.
- The existing tax exclusion for employer-provided benefits would be retained.

4. Enrollment Process

- All individuals would have the option of enrolling in the state pool each year during a one-month open enrollment period.
- People can enroll in the pool at other times during the year. However, to prevent people from “gaming the system” by waiting until they have health care needs to enroll, they must retroactively pay one year of premiums plus a penalty of 25 percent of the premium amount.
- This approach effectively eliminates medically needy spend-down as a means of becoming eligible.
- The penalty for enrolling outside the open enrollment period is waived in cases where the individual has involuntarily lost coverage outside of the pool. We also assume that the penalty is waived in cases where the individual qualifies for full premium subsidies. This is intended to maintain eligibility for persons that would be eligible under the current Medicaid and SCHIP programs.

5. Managed Competition

The proposal includes elements of the managed competition model that are designed to give individuals financial incentives to enroll in more cost-efficient health plans. In general, the plan would require all individuals to pay the full additional cost of enrolling in higher-cost and/or less efficient health plans. These include:

- The program would use a competitive bidding process to determine premium levels in the public plan. Persons enrolling in plans more costly than the “benchmark” rate (i.e., median bid or some other midpoint measure) would pay the full additional cost of enrolling in that plan.
- Employers are required to make a uniform contribution to all workers, including those who enroll in the public plan, regardless of the plan selected. This effectively requires employers to require that employees pay the full additional cost of enrolling in a higher-cost plan.

6. Financing

- The public cost of the program would be equal to total benefits and administrative costs under the state pools less the amount of premiums collected from participants, including premium contributions paid by employers for pool enrollees. This effectively includes:
 - Premium subsidies for lower income persons enrolled in the program; and
 - Costs in excess of the community-rated premium resulting from adverse selection into the plan by higher-cost individuals and groups.

- Participating states would share this cost with the federal government according to a matching rate that is about 30 percent greater than under the current Medicaid program. Costs for elements of the Medicaid program that are not moved to the state pool also would be matched at the enhanced rate in participating states.
- Any net increase in costs to states would be offset by reduced need for other indigent care programs such as:
 - Public hospital funding;
 - State coverage for low-income non-Medicaid population (i.e., “state only Medicaid”);
 - State contributions for Disproportionate Share Hospital (DSH) benefits (excluding state match from intergovernmental transfers); and
 - Other state programs.
- Some of these savings would accrue to local governments as well.
- Net costs to the federal government would be partly offset by savings in federal indigent care programs, including DSH funding.
- Savings to employers would result in higher wages (see assumptions below) resulting in an increase in federal and state tax revenues.
- The net increases in state and federal costs under the proposal are assumed to be financed through an increase in state and federal income taxes (i.e., progressive financing).

B. Key Assumptions

The authors’ proposal includes several voluntary elements that together determine the level of coverage and public spending under the program. For example, while the subsidies provided under the program expand access to coverage, employers are not required to contribute to the cost of worker coverage and individuals are not required to have insurance. Also, individuals generally would have a choice of health plans with financial incentives to enroll in more cost-efficient plans, which would affect program spending. Therefore, to estimate the impacts of this program, we needed to simulate the choices made by employers and consumers subject to the various incentives created by the program.

These estimates were developed using the Lewin Group Health Benefits Simulation Model (HBSM), which is based upon data from the 1996 Medical Expenditures Panel Survey (MEPS) and the 2001 Current Population Survey (CPS). Workers in these data are also matched to individual firms in the 1999 Kaiser/HRET Annual Employer Health Benefits Survey to enable us to model the impact of firm-level decisions affecting worker

coverage. The data and methods used are presented in *Appendix A* of this report. The key assumptions used in this analysis are discussed in the following sections:

- State decisions under proposal;
- Public plan enrollment;
- Employer coverage;
- Individual coverage;
- Managed competition effects;
- Medicaid;
- Administrative costs; and
- Wage effects.

1. State Decisions Under Proposal

The program is designed to encourage states to voluntarily establish these public plans and provide premium subsidies for persons living below 250 percent of the FPL. States also have the option of providing subsidies above this income level.

For illustrative purposes, we have assumed the following concerning state behavior:

- All states are assumed to participate and that all would provide subsidies to persons through 250 percent of the FPL as envisioned in the proposal.
- We assume that none of the states extend eligibility beyond 250 percent of the FPL except for eligible persons in states with Medicaid income eligibility levels that are currently beyond this income level.
- We assume that all states would permit insurer rates to vary by age up to a maximum of +/- 50 percent.

2. Public Plan Enrollment

As discussed above, the proposal would provide fully subsidized coverage for all persons living below 150 percent of the FPL and partially subsidized coverage for persons with incomes between 150 percent and 250 percent of the FPL. In this analysis, we estimated enrollment based upon a Lewin Group multivariate model of enrollment in Medicaid and other public programs with partial premium subsidies.

We estimated the number of persons eligible for this coverage expansion program using from the CPS data and the MEPS data that form the basis of the HBSM baseline scenario.¹ These data provide information on income and insurance coverage for a representative sample of the population that is suitable for use in estimating the number of persons who are eligible for public coverage expansions.²

Key assumptions include:

Current Medicaid and SCHIP Enrollees:

- We assume that all Medicaid and SCHIP enrollees would be shifted to the new public plan except the aged and the disabled receiving Supplemental Security Income (SSI) payments.³ The current Medicaid program would be retained for these persons.

Persons without Access to Employer Coverage:

- For income-eligible persons who are not required to make a premium contribution (i.e., persons below 150 percent of the FPL), we estimated the number of newly eligible persons who enroll based upon a Lewin Group analysis of program participation rates under the current Medicaid program. This approach results in participation rates of about 70 percent for uninsured persons and 45 percent for persons currently covered from some other source.
- For persons required to pay a partial premium (i.e., persons between 150 percent and 250 percent of the FPL), we estimated enrollment for newly eligible persons based upon a Lewin Group multivariate analysis of how enrollment varies with the amount of the premium. This analysis, which is based upon experience in MinnesotaCare and the Washington Basic Health Plans, indicates that enrollment rates decline by about 37 percent when a premium is required and that enrollment declines as the amount of the premium increases.
- We assumed that currently eligible children who are not enrolled become covered under the program if one of their parents enrolls under the new public plan. We assume no change in coverage status for all other persons who are eligible for but not enrolled in the existing Medicaid/SCHIP program.

¹ The methods used are presented in: “Health Coverage 2000: Cost and Coverage Analysis of Eight Proposals to Expand Health Insurance Coverage”, (Report to the Robert Wood Johnson Foundation (RWJF))”, The Lewin Group, September 2000.

² For major expansions in eligibility, we use the most recent CPS data (i.e., 2001). When simulating the impact of eligibility expansions for small eligibility groups or at the state level, we pool the CPS data for the most recent four years (i.e., 1998 through 2001).

³ By extending coverage to 150 percent of the FPL for all persons including non-custodial adults, disabled people would be able to qualify on the basis of income alone without identifying themselves as disabled. Consequently, the state would know an individual’s disability status only in cases where the individual has qualified for SSI benefits on the basis of disability.

Workers in Firms that Sponsor Coverage:

- All firms must make coverage under the public pool available to all workers, even if they sponsor private coverage alternatives.
- We assume that all persons eligible for a subsidy would shift to the public plan in cases where their net premium payment in the public plan is less than the amount the worker would pay for coverage under the employer's private plan. Otherwise they would take coverage under the private plan.
- Some employers may offer coverage through the public pool only. All employees of these firms are assumed to be covered under the public plan.

3. Employer Coverage

The authors' proposal is designed to expand private insurance coverage by permitting employers to shift their higher-cost workers and families to the community-rated public plan, while covering the remainder of their workforce under private coverage. Private insurance premiums would decline as higher-cost individuals are shifted to the public plan, resulting in an increase in the number of employers offering private insurance.

The methods used to simulate these effects are summarized in the following sections:

- Synthetic firm data;
- Enrollment in the public plan;
- Employer decision to offer coverage; and
- Benefits variation.

Creation of Synthetic Firms: The simulation of the employer coverage decision was based upon a database of "synthetic firms" developed using HBSM. Each worker in the MEPS data was assigned to one of the employers in the 1999 Kaiser/HRET data. We then "populated" the firm to which each worker has been assigned by randomly selecting MEPS workers who match the economic and demographic profile of persons employed by that firm.⁴

For example, the firm assigned to a given MEPS worker that has 5 employees would be populated by that worker plus another four MEPS workers chosen at random who also fit the employer's workforce profile. If this individual is in a firm with 1,000 workers, they are assigned to a Kaiser/HRET employer of that size and the firm is populated with that

⁴ The Kaiser/HRET data provide information on the wage profile, industry and firm size characteristics of each firm. We then statistically matched these data with the 1991 employer survey conducted by the Health Insurance Association of America (HIAA), which provides additional demographic detail including age, gender, part-time/full-time status, and family/single covered status.

individual plus another 999 MEPS workers. This process is repeated for each worker in these data to produce one synthetic firm for each MEPS worker.

Health care costs for the group are assumed to be equal to the individual worker's costs plus the costs for other persons assigned to the firm. Costs also include expenditures for dependent spouses and children. This approach assures that the costs for each synthetic firm reflects the actual level of utilization for each MEPS worker, plus the others assigned to the firm.⁵

The model was used to estimate the premium for each of these synthetic firms under a single benefits package. We assumed a uniform benefits package based upon the benefits provided through the Federal Employees Health Benefits Program (FEHBP). The private coverage premium for each synthetic firm was estimated as follows:

- For self-funding firms, the “premium” is equal to the average cost per worker assigned to each firm for single and family coverage;
- For fully insured firms subject to state rating regulations, premiums are based upon a simulation of small group premium rating in each state including community rating, age rating, and rating bands. These requirements impose varying degrees of risk pooling in the small group market that we simulate by pooling the workers in these synthetic firms. Premiums are based upon average costs by age and gender, which are compressed into fewer age groupings in states that limit rate variations; and
- For fully insured groups subject to experience rating, premiums are estimated based upon actual health expenditures for persons assigned to the firm, and an analysis of the degree to which expenditures in one year predict the level of spending in the next.

Enrollment in the Public Plan: The authors' proposal would create an opportunity for employers to reduce their health benefits costs by offering coverage options in both the public and private plans. Under the proposal, all employers are required to make coverage available to their workers in the public plan. Employers also have the option of offering private insurance alternatives.

This structure allows the employer to design their private coverage alternatives in a way that encourages higher-cost workers and families to enroll in the public plan while retaining the less costly portion of their workforce under private plans. For example, an employer could offer private plans with only basic health benefits provided through managed care plans, while also allowing workers to take the more comprehensive coverage alternatives available through the public plan. This benefits design strategy would shift most higher-cost workers and families to the public plan where the better coverage would be available, leaving the lower-cost population in the private plans.

The concentration of lower-cost persons in the private health plans would reduce premiums in the private sector, which is designed to encourage non-insuring employers

⁵ The method for developing synthetic firms is described in detail in Appendix A of this report.

to sponsor coverage. Although the accumulation of higher-cost individuals in the public plan would increase per-person costs in the plan, premiums for the public plan would not increase. This is because the program requires that the premium be set on the basis of average costs in the non-Medicare population regardless of the actual level of spending for those who actually enroll in the public plan. The government-funded program would cover public plan costs in excess of premium revenues.

We modeled this selection behavior based upon the assumption that employers will succeed in designing coverage alternatives that attract high-cost workers to the public pool. We did this by estimating the “expected” level of health spending for each individual in the model at the start of the simulation year based upon spending in the prior year. We then assumed that people with higher than average expected spending enroll in the public plan, with all others enrolling in private plans.

The first step in this process was to estimate “expected health spending” for each worker family based upon MEPS data on health spending for individuals in two consecutive years. We used these data to divide workers by decile ranking of health spending in the first year (1996). We then calculated average spending for persons in the second year (1997) for persons in each of the 1996 decile groups. The result is an estimate of expected spending in one year given the level of spending in the prior year (actual spending will vary on an individual basis). These data represent the expected level of health spending for individuals at the start of the simulation year.⁶

We then assumed that employers are successful in designing their health plans so that workers with expected spending in excess of average spending select plans in the public pool. Those with lower expected spending enroll in the private plans. Expenditures in the public and private pools were then computed from the actual health spending data reported for worker families assigned to each pool (the amount reported for each individual varies from the expected amount but is on average equal to the expected amount). Premiums in the private insurance pool were adjusted downward to reflect the impact that this selection behavior would have on private insurance premiums.

We modified this approach to reflect the fact that premium subsidies are available to only those who enroll in the public plan. We assume that in firms that decide to also offer private coverage, below-average cost workers automatically enroll in the private plans, unless they qualify for a subsidy. In these cases, we assume that these workers would enroll in the public plan if the worker share of the public plan premium less subsidies (premium subsidies are available only in the public plan) is less than the worker share of the premium in the private health plan.

As discussed below, we simulated the increase in coverage that would result from these private insurance premium reductions. The assumptions that we have used here result in

⁶ The 1996/1997 MEPS data were used to estimate a matrix showing the distribution of persons by decile ranking of health spending in 1996 by decile ranking of spending in 1997. This matrix was used to impute a decile ranking of spending during the prior year for each worker in the HBSM household database. The expected level of spending for each HBSM individual at the start of the simulation year was estimated by tabulating average spending for HBSM individuals by their imputed decile ranking for the prior year.

the lowest premiums possible for private coverage, thus illustrating the maximum increase in coverage that could occur under the program, given the price elasticity estimates that we are using and the effects that premium subsidies would have on the selection of health plans. This simulation is repeated iteratively to reflect the fact that the migration of some lower-cost people to the public plan would lead to higher private plan premiums, which would in turn affect the number of firms offering coverage.

Limits on Employer Response: These assumptions imply that all employers would establish a multiple offering of health plans that generates adverse selection into the public pool. However, not all firms will behave this way. Many employers may simply choose to give their workers access to the public pool, as required under the proposal, without also offering a private coverage alternative. Such behavior would tend to reduce the amount of adverse selection under the program.

To account for this, we assumed that firms that do not provide a multiple offering of health plan options under current law would provide coverage only through the public plan in cases where the public plan premium is less than the premium they would pay for private coverage (after adjustment for reduced private-sector costs).

Employer Decision to Offer Coverage: The program would reduce the premiums paid by many employers for coverage in two ways.

- First, in many instances, the premium in the public plan would be less than what many employers now face in the insurance markets; and
- Second, the shift of higher-cost persons to the public plan would reduce premiums in the private sector.

Thus, the authors' proposal would increase the number of employers offering coverage by lowering the premium that they would pay.

We simulated the impact that this would have on the number of employers sponsoring coverage based upon a Lewin Group analysis of the relationship between premiums and the likelihood of providing coverage based upon the 1997 survey of employers sponsored by the Robert Wood Johnson Foundation (RWJF). These analyses show employer price elasticity estimates ranging from -0.46 percent for firms with under 10 workers to -0.07 percent for firms with over 1,000 workers.

We simulated this uptake in coverage in the following steps:

- As discussed above, we estimated the premium that would be paid by each synthetic non-insuring firm in the model in the current market;
- We then calculated the premium for the group under the proposal, which is the lesser of the public plan premium or the premium in the private market after adjustment for the shift of higher-cost persons to the public pool;

- In cases where the cost of coverage for the group is less than the premium they now face, firms are randomly selected to enroll based upon the price elasticity estimates described above;
- The portion of the premium paid by the employer is estimated for every firm that is simulated to offer coverage based upon a multivariate analysis of employer contribution levels as reported in the 1997 RWJF data; and
- Workers who are offered coverage in these newly insuring firms are selected to enroll based upon a multivariate analysis of MEPS data on employee take-up rates in employer-sponsored plans by worker characteristics and employee contribution requirement. For workers with no other source of coverage, the take-up rate averages about 95 percent.

Benefit Variations: The authors' plan would not establish a minimum benefits package, resulting in a range of coverage options available through the public plan. However, as discussed above, we assumed a single uniform benefits package for purposes of simulating the employer choice of health plans. To reflect the likely variation in coverage purchased in the public plan, we assume that the plans purchased in the public pool are similar to those of the private plan they now have. We simulated this by assuming that the benefits covered under the public plan for employer groups would be the same as they would be under their current plan (i.e., currently covered services).

4. Individual coverage

People currently purchasing individual non-group coverage also would have the option of enrolling in the public program. We simulated this decision by estimating the premium that these individuals would pay in the current private market for a given benefits plan. We then assume that these individuals would shift coverage to the public plan if the public plan premium is less than our estimate of the premium they would pay in the private market.

A key element in this step was estimating the amount of the premium individuals would pay in the private market. The premium that an individual pays tends to reflect health status due to age rating and medical underwriting, which is more prevalent in the individual market. We estimated premiums for these individuals by assigning them an average expected cost that varies with age, gender and self-reported health status. These average cost amounts were estimated in HBSM using the data reported for persons potentially eligible to enroll in the public plan.

In this analysis, we assumed that individuals currently purchasing non-group coverage would enroll in the public plan if the public plan premium is less than the estimated private market premium.

5. *Managed Competition Effects*

The authors' proposal would require persons in the public plan to pay the full additional cost of enrolling in plans more costly than the median cost plan in the area. The proposal also requires employers with a selection of health plans to make a uniform contribution for each employee regardless of whether the employer is offering coverage through the public plan or private coverage. These provisions create incentives for individuals to enroll in lower-cost plans, resulting in savings. We estimated these savings based upon a simulation of the effect that this would have on enrollment in various types of health plans.

We assume that the program's primary effect would be to shift individuals from fee-for-service (FFS) plans (including PPO or POS plans) to HMOs, where costs are typically lower for a given level of coverage. Based upon available research, we assume that HMOs are about 12.0 percent less costly than fee-for-service plans, which we use as a proxy measure of the increment of cost for staying with a higher-cost plan.⁷

Our approach was to simulate the shift to HMOs based upon the change in out-of-pocket premium payments under the proposal and published price elasticity estimates for health coverage. Premiums were defined as follows:

- **Current policy premiums:** For persons with employer coverage, out-of-pocket premium expenses under current policy were defined to include employee premium contributions less the tax savings resulting from the tax exclusion for the employee contribution. For persons with non-group coverage, the out-of-pocket premium includes the full amount of the premium paid for the policy.
- **Premiums under proposal:** Premiums under the policy are assumed to be equal to current out-of-pocket premiums plus the amount that an individual would pay above the median cost plan premium to continue with their current FFS coverage, less the tax savings resulting from the tax exclusion for employee health benefits (i.e., in section 125 plans). We assume that this amount is equal to 12 percent of the total premium (including employee and employer share) for their current FFS plan.

We also assume that the price elasticity for coverage in multiple choice offerings (i.e., plans offering a choice of coverage options) varies with age and health risk, averaging -2.47 . (The elasticity ranges from -3.5 for persons under the age of 31 who are at a low risk for health expenditures to -1.38 for high-risk individuals over the age of 45.)⁸ Individuals were randomly selected to shift to an HMO based upon these price and price elasticity data.⁹ We then assumed that expenditures for these individuals are reduced by 12.0 percent.

⁷ "New Evidence on Savings from Network Models of Managed Care," (report to the Healthcare Leadership Council), The Lewin Group, Washington, DC, May 1994.

⁸ Strombom, Bruce A., Buchmueller, Thomas C., Feldstein, Paul J., "Switching Costs, Price Sensitivity and Health Plan Choice", *Journal of Health Economics*, October 2001.

⁹ Newly insured persons were randomly assigned to HMOs based upon the percentage of privately insured persons who are in HMOs after we have executed our simulation for currently insured persons.

We assumed no savings among persons who are currently enrolled in HMOs. Persons who are currently in multiple choice offerings with a fixed employer contribution were also assumed to remain with their current coverage. This is because these individuals already choose a higher-priced plan, despite the fixed employer contribution and are not likely to change their health plans.

In addition, based upon the available research, we assume that the rate of growth in health spending is reduced as the percentage of persons enrolled in HMOs increases. Studies indicate that a 10 percent increase in the number of persons enrolled in plans with selective contracting is associated with a reduction in the annual rate of growth in hospital spending of up to 1.5 percent.¹⁰

6. Medicaid

We made the following assumptions concerning the Medicaid population under the authors' proposal:

- All aged individuals and disabled persons enrolled in SSI would continue to be enrolled in Medicaid.
- The medically needy and the non-SSI disabled would no longer be identified due to the availability of subsidized coverage for all low-income persons including non-custodial adults, regardless of disability status.¹¹ These individuals would become part of the public plan insurance pool along with all other non-aged non-SSI disabled persons, which would tend to increase public plan premiums (reflected in estimates).
- Provider reimbursement levels for persons formerly covered by Medicaid would be increased to private sector levels (estimated average increase of 20 percent).

7. Administrative Costs

There are three types of administrative costs that were estimated for this program:

- Insurer administrative costs;
- Administrative costs in the public plan; and
- Administration of subsidies.

Insurer administrative costs: Insurer administrative costs in the public plan are assumed to be about 19 percent of benefits costs for the self-employed and non-group enrollees. This rate of administration is based upon the administrative overhead rates

¹⁰ Robinson, J.C., "HMO Market Penetration and Hospital Cost Inflation in California," *Journal of the American Medical Association*, 266 (20 November 1991): 2719-23.

¹¹ The SSI disabled would continue to present themselves as they apply for disability income benefits under SSI.

experienced in large non-group plans. We assume that administrative costs for employer groups, which vary from as high as 40 percent in small firms to 3.5 percent in the largest firms, would be the same as in existing employer health plans, up to a maximum of 19 percent. This reflects the fact that small groups would continue to be more costly to administer than larger firms, even in the public pools.

We also assumed that administrative costs for Medicaid recipients who are shifted to private coverage through the public plan would be 19 percent. However, we assumed that this increase in administrative costs would occur among only the portion of Medicaid beneficiaries who are not already enrolled in private managed care plans.

Public pool administrative costs: These include the cost of processing enrollment in the various plans, premiums collections where necessary, and payments to health plans. Many of these functions are currently performed by insurers and are accounted for in the insurer administrative costs estimated as described above. In this analysis, we allocated the portion of insurer administrative costs estimated above for functions that would be performed by the public plans. We assumed that the cost of administering the pool would be equal to about 4.5 percent of covered claims. This is based upon the cost of administration under the California Pac Advantage Program, which provides a selection of health plans for small employers in California (this also includes the cost of a risk adjustment mechanism to correct for risk selection).

Administration of subsidies: It is difficult to estimate the cost of administering the premium subsidies under the program. The authors propose to administer subsidies through the public plan and the federal income tax withholding system. This approach is potentially less costly than using a system similar to that used to determine eligibility under the Medicaid and SCHIP programs, which costs about \$190 per family per year.¹² However, we have little information upon which to base an estimate of the cost of administering subsidies under the program.

For illustrative purposes, we made some simplifying assumptions concerning the cost of administering eligibility under the program. For persons without employer subsidized coverage, costs are assumed to equal \$190 per family as under the Medicaid/SCHIP program. For persons with employer coverage, the cost of administering the subsidy is assumed to be half that amount, reflecting the fact that under the proposal, the employer would assist in these functions.

8. Wage Effects

We assume that any savings in employer health spending resulting from enrolling in the public plan would be passed on to employees as an increase in wages (adjusted for the employer's share of the Social Security payroll tax on this wage increase). This wage increase for the worker would be partly offset by the increased income and payroll tax payments that workers would pay on this wage increase.

¹² Estimated from detailed administrative data for the California Medicaid program (i.e., Medi-Cal).

C. Program Impacts Estimates

We present our estimates in two ways. First, we present estimates of the cost and coverage impacts of this proposal assuming full implementation in 2002. These estimates are useful for comparing program impacts at current levels of health care costs and numbers of persons without health insurance. Second, for budgetary purposes, we also present year-by-year cost estimates for 2003 through 2012, which reflect the expected dates of program implementation.

These results are presented in the following sections:

- Sources of coverage;
- Premiums in the public plan;
- Impact on national health expenditures;
- Federal program costs;
- Impact on state and local governments;
- Employer impacts;
- Impacts on households; and
- Expenditures in future years.

1. Sources of Coverage

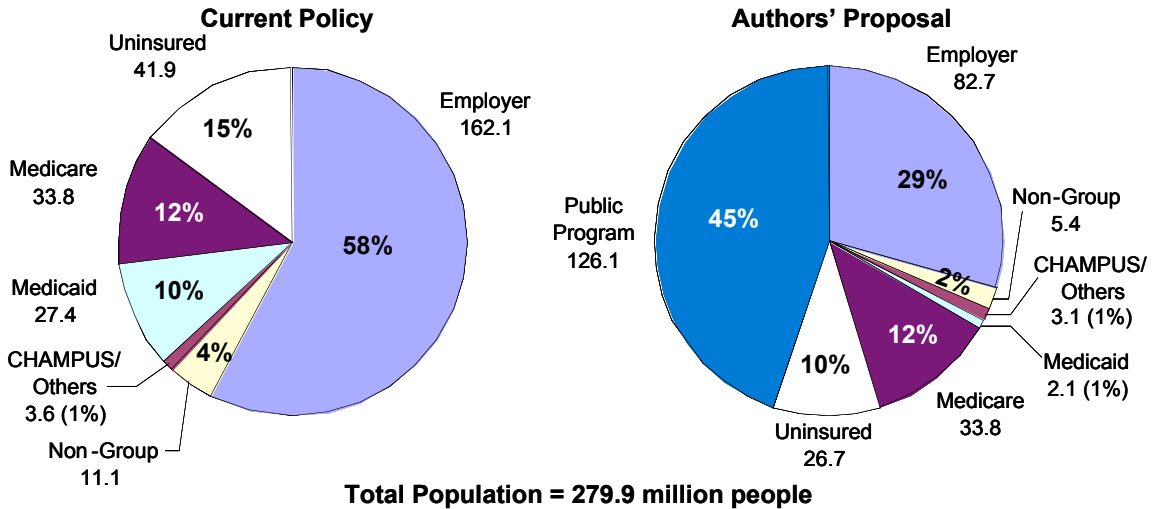
The authors' proposal would change the source of insurance coverage for most non-elderly Americans. The plan would reduce the number of uninsured by about 15.2 million persons. This is a reduction of about 36.3 percent from our estimate of 41.9 million uninsured persons under current law (average monthly count) in 2002 (*Figure 1*).¹³

Coverage in employer sponsored plans would drop from 162.1 million persons under current law to 82.7 million persons as income eligible workers shift to the public plan to receive premium subsidies. (Subsidies are available only in the public plan.) Private non-group coverage would decline from 11.1 million persons to 5.4 million persons, also due to the availability of subsidies under the public plan.

About 25.3 million people currently enrolled in Medicaid/SCHIP would be shifted to the new public plan, leaving about 2.1 million persons with Medicaid as their primary source of coverage. Those who continue to have Medicaid as their primary source of insurance would be disabled persons receiving cash benefits under the Supplemental Security Income (SSI) program, and a small number of aged persons who do not qualify for Medicare.

¹³ All population counts in this analysis represent average monthly enrollment by coverage source.

Figure 1
Distribution of Persons by Primary Source of Coverage under Current Policy and the Authors' Proposal in 2002^{a/}
(in millions)

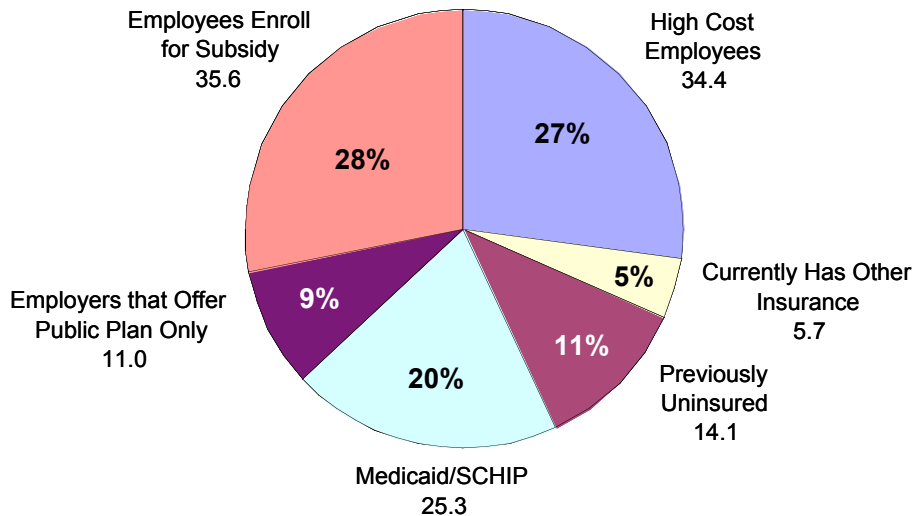


a/ Coverage presented on an average monthly basis.

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

Based upon our simulation of employer and consumer decision making described above, we estimate that there would be about 126.1 million persons enrolled in the public plan. **Figure 2** presents the distribution of enrollees in the public plan by reason for enrollment. These include:

Figure 2
Distribution of Persons in the Public Program by Prior Source of Coverage in 2002 (in millions)



Number of Persons in Program = 125.1 million

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

- The public plan would include about 34.4 million workers and dependents with above-average expected health care costs who we have assumed enroll in the public plan to obtain better coverage (see assumptions discussion above);
- About 35.6 million of these enrollees would be workers and dependents who shift to the public plan because it is less costly, typically due to the availability of subsidies in the public plan;
- We estimate that there are about 11.0 million workers and dependents in firms that would elect to offer coverage through the public plan only (see assumptions discussion above);
- About 25.3 million enrollees would be Medicaid and SCHIP beneficiaries transferred to the public plan for coverage;
- The public pool would also cover about 14.1 million newly insured persons who do not have access to employer coverage. Most of these people receive subsidies; and
- About 5.7 million persons who currently have other insurance coverage who would join the pool because it is less costly, usually due to premium subsidies.

Figure 3 (on the next page) summarizes the transitions in coverage under the authors' proposal.

2. Public Plan Premium

Premiums in the public plan would be community rated on the basis of costs for the entire non-Medicare population. As discussed above, we estimated these community rates based upon a benefits package modeled on the coverage typically provided under the FEHBP program for federal government workers. We estimated the community-rated premiums on a per-member per-month (PMPM) basis with HBSM based upon the expenditures reported in the MEPS data. *Figure 4* presents our estimates of the community-rated “pure premium” cost (i.e., benefits costs excluding administration) by type of family and per covered person on a PMPM basis.

Average costs per person would be \$203 PMPM. However, the public program would tend to attract employers and individuals who find that the community-rated premium is less than what they would pay for private coverage. We estimate that average costs among those who enroll in the public plan would be \$242 PMPM.

The firms that are expected to continue to provide coverage would be those in which private premiums are lower than in the public plan. Costs for persons in firms that continue to be covered under private plans would be \$169 PMPM.

Figure 3
Coverage Transitions Under the Authors' Proposal
(in millions)

		Primary Sources of Coverage Under Proposal							
		Public Program		Private Coverage		Other Sources			
Base Case Coverage	Total	Employer	Individual	Employer	Non-group	CHAMPUS	Medicare	Medicaid	Uninsured
Employer	162.1	81.0	0	81.1	0	0	0	0	0
Non-Group	11.1	0	5.2	0.5	5.4	0	0	0	0
CHAMPUS	3.6	0	0.5	0	0	3.1	0	0	0
Medicare	33.8	0	0	0	0	0	33.8	0	0
Medicaid	27.4	0	25.3	0	0	0	0	2.1	0
Uninsured	41.9	0.8	13.3	1.1	0	0	0	0	26.7
Total	279.9	81.8	44.3	82.7	5.4	3.1	33.8	2.1	26.7

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

Figure 4
Community-Rated Pure Premium for Public Plan and for Privately Insured a/

	Population-based Community Rate b/	Costs in the Public Plan	Costs for Firms in Private Plans
Individual	\$233	\$274	\$170
Couple	\$465	\$549	\$340
Two Parent	\$658	\$815	\$536
One Parent	\$437	\$516	\$371
Per Person	\$203	\$242	\$169

a/ Includes benefits costs excluding program administration on a per-member, per-month basis (PMPM).

Estimates assume a uniform benefits package.

b/ Shown are the average pure premium amount by family type. Age adjusted rates were used for the simulations.

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

3. Impact on National Health Expenditures

Health expenditures in the United States are projected to reach about \$1.5 trillion in 2002. We estimate that national health spending would increase by about \$34.0 billion under the authors' proposal (*Figure 5*). Payments for health services would increase by about \$24.0 billion due to increased access to health services for newly insured persons and various effects of the program on utilization and provider reimbursement. Administrative costs would increase by about \$10.0 billion as coverage and subsidies are extended to new populations.

Figure 5
Changes in National Health Spending Under the Authors' Proposal in 2002
(in billions)

Change in health services expenditures		\$24.0
Change in utilization for newly insured	\$13.5	
Change in utilization due to improved coverage	\$9.4	
Managed competition savings	(\$13.4)	
Reimbursement effects	\$14.5	
Reimbursement increase for Medicaid population	\$13.4	
Payments for uncompensated care	\$10.7	
Reduced cost shifting	(\$9.6)	
Change in Administrative Costs		\$10.0
Insured administration	\$5.7	
Administration of subsidies	\$4.3	
Total Change in Health Spending		\$34.0

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

Utilization of health services among newly insured persons and persons with improved coverage would increase by about \$22.9 billion. Spending would also increase by about \$14.5 billion as current Medicaid/SCHIP enrollees become covered under private health plans where provider reimbursement rates are about 20 percent higher than in Medicaid.

These increases in cost would be partly offset by managed competition savings of \$13.4 billion.¹⁴

Also, a portion of the care that is now provided as uncompensated care would become reimbursable due to the insurance expansion, resulting in an additional increase in provider income of about \$10.7 billion. We assume that about 40 percent of the increase in payments for Medicaid (i.e., \$13.4 billion) and uninsured persons (i.e., \$10.7 billion) would be passed on to private health plans in the form of reduced cost-shifting, resulting in a total net increase in provider revenues of \$14.5 billion.

Insurer/health plan administrative costs would increase by about \$5.7 billion. This reflects the cost of administering insurance for newly insured persons and the added cost of covering the Medicaid population under private health plans. In addition, we estimate that administering premium and cost sharing subsidies for families would add an additional \$4.3 billion in administrative costs (over and above eligibility administration in the current Medicaid program).

Figure 6 summarizes how these changes in spending are distributed over major stakeholder groups. Initially, federal spending on health care would increase by about \$139.5 billion while employers, households, and state and local governments would see savings. However, economic theory and evidence indicates that wages would be bid-up to reflect the savings in health benefits expenditures (i.e., \$35.6 billion), resulting in increased wage income for households.

Figure 6
Change in Health Spending by Stakeholder Group in 2002
(in billions)

	Without Wage Effects	With Wage Effects	With Wage Effects and Fully Financed
Federal Government	\$139.5	\$127.4	--
State and Local Government	(\$14.8)	(\$12.5)	(\$12.5)
Private Employers	(\$35.6)	\$0.8	\$0.8
Households	(\$55.1)	(\$81.7)	\$45.7
Total Health Spending	\$34.0	\$34.0	\$34.0

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

These savings to households would be more than offset by an increase in the personal income tax to cover the federal cost of the program. Thus, households would eventually pay nearly all of the cost of the increase in national health spending. *Figure 6* presents the impact on various stakeholder groups in greater detail.

¹⁴ Includes savings from provisions requiring individuals to pay the full increment of cost associated with enrollment in a health plan where the costs exceed the median cost plan.

4. Program spending

Total program spending would be \$214.0 billion if fully implemented in 2002 (*Figure 7*). Program spending would include about \$130.0 billion in premium subsidies and about \$11.7 billion in cost sharing subsidies. In fact, we estimate that roughly one-third of all families and single individuals would receive a subsidy. The cost of determining eligibility and subsidy amounts for this population would be about \$6.7 billion.

In addition, the program would provide about \$65.6 billion in subsidies to higher-cost individuals and groups who take advantage of the community rate under the public plan. Total benefits costs for persons covered under the public program would be \$380.2 billion, while community-rated premiums for enrollees would be about \$314.6 billion (i.e., premium obligations before premium subsidies).

These estimates reflect the fact that the current Medicaid and SCHIP coverage for non-disabled non-aged persons would be folded into the public program.¹⁵ However, the Medicaid program would be retained in its current form for aged and disabled persons, and long-term care. Federal disproportionate share hospital payments would also be continued. Total spending for these elements of the program would be \$158.6 billion (*Figure 7*).

Figure 7
Expenditures under Public Plans and Continued Medicaid Programs
(in billions)

	Total	Federal	State
Public Plan Costs			
Premium Subsidies	\$130.0	\$94.8	\$35.2
Cost sharing Subsidies	\$11.7	\$8.5	\$3.2
Administration of Subsidies	\$6.7	\$4.9	\$1.8
Public Program Operations:	\$65.6	\$47.8	\$17.8
Benefits and Administration	\$380.2		
Less Premium Revenues	(\$314.6)		
Subtotal Program Costs	\$214.0	\$156.0	\$58.0
Continued Medicaid Program			
Aged and Disabled	\$57.1	\$41.6	\$15.5
Long-term Care	\$56.1	\$40.9	\$15.2
DSH (Federal only)	\$8.8	\$8.8	\$0.0
Other	\$23.3	\$17.0	\$6.3
Administration	\$13.3	\$9.7	\$3.6
Subtotal Continued Medicaid Program	\$158.6	\$118.0	\$40.6
Total Program Costs			
Total Program Costs	\$372.6	\$274.0	\$98.6

a/ The average federal match rate would be about 72.9 percent.

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

¹⁵ Spending for the acute care population would be about \$66.9 billion in 2002 including benefits and administration.

The combined cost of the newly created public plan and the continued portions of Medicaid would be \$372.6 billion if fully implemented in 2002. As discussed above, the federal government would match state spending under both the newly created public programs and the continued portions of Medicaid at an enhanced matching rate (i.e., the current federal matching rate plus 30 percent). Of the \$372.6 billion in spending under these programs, the federal government would pay \$274.0 billion with the states paying the remainder of 98.6 billion.

5. Federal Expenditures

Total federal spending under the program would be \$274.0 billion if implemented in 2002. This includes the federal share of all subsidies provided through the public plan and the federal cost of the portions of Medicaid that would be continued under the proposal (*Figure 8*).

Figure 8
Changes in the Federal Spending Under the Authors Proposal

	Change in Spending
Federal Share of Spending under Program	\$274.0
Public Plans \$156.0	
Continued Medicaid \$118.0	
Offsets	
Current Medicaid Funding (Federal)	\$131.9
Other Program Offsets	\$2.6
Revenues Due to Wage Effects	\$12.1
Total Offsets	\$146.6
Net Cost to Federal Government	
Amount Raised through Income Tax Increase	\$127.4

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

The program would be partly financed with the \$131.9 billion in funds that would have been used for the Medicaid and SCHIP programs in 2002. The federal government would also see an increase in revenues of about \$12.1 billion due to the increase in wages resulting from reduction in employer health benefits costs under the proposal. Total revenues and offsets from all sources would be \$146.6 billion, leaving about \$127.4 billion to be raised through an increase in the personal income tax.

6. Impact on State and Local Governments

As discussed above, the state share of costs under the program would be \$98.6 billion (*Figure 9*). This includes the state share of costs for the newly created public plans and the portions of Medicaid that are retained under this proposal. These figures reflect the 30 percent increase in the federal matching rate under this proposal. These costs (\$98.6 billion) would be almost exactly offset by the amount that states would have spent under the existing Medicaid and SCHIP programs in 2002 (\$95.8 billion).

Figure 9
Change in Health Spending for State and Local Governments

		Change in Spending
State Share of Program Spending		\$98.6
New Public Plans	\$58.0	
Continued Medicaid	\$40.6	
Offsets		
Current Medicaid Funding		\$95.8
Savings to Other Safety-net Programs		\$13.5
State and Local Worker Health Benefits Savings/(increase)		\$0.3
Savings for Workers and Dependents	\$3.8	
Savings for Retirees	0.3	
Wage Effect Offset	(\$3.8)	
Tax Revenue from Wage Effect		\$1.5
Total Offsets		\$111.1
Net Cost to State and Local Governments		
Net Savings		\$12.5

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

However, state and local governments would also see savings of about \$13.5 billion in other safety-net programs for the medically indigent as the number of uninsured is reduced. Some of these savings are also due to increases in covered services for persons affected by the minimum benefits requirement under the public program.

State and local governments would have the option of covering their workers under the public plan. This would tend to occur in cases where the public plan premium is less than what the state would pay for private coverage. We estimate that total savings would be \$4.1 billion to state and local governments (\$3.8 billion for workers and dependents and 0.3 billion for retirees). However, as discussed above, we assume that these savings (except retiree benefit savings) are eventually passed-on to workers in the form of higher wages, with little net impact on state spending. Thus, after accounting for wage effects, state and local worker benefits programs save about \$0.3 billion.

In addition, state and local governments with income taxes would see increased revenues resulting from the wage effect for affected workers. Total net savings to state and local governments including revenue offsets would be about \$12.5 billion.

7. Private Employer Impacts

We estimate that private employers spent about \$284.3 billion on health benefits in 2002 (**Figure 10**). This includes total benefits and insurer administrative costs less employee premium contributions. Private employer spending (i.e., \$284.3) includes about \$264.7 billion in spending for workers and dependents and \$19.5 billion in retiree benefits.

We estimate that health spending among firms that currently provide coverage would decline by about \$38.2 billion under the program. This include savings from employers

who shift to the public plan in cases where the public plan premium is less than what they would pay for comparable coverage in the private market.

Figure 10
Changes in Private Employer Health Benefits Costs by
Current Insuring Status in 2002 (in billions)

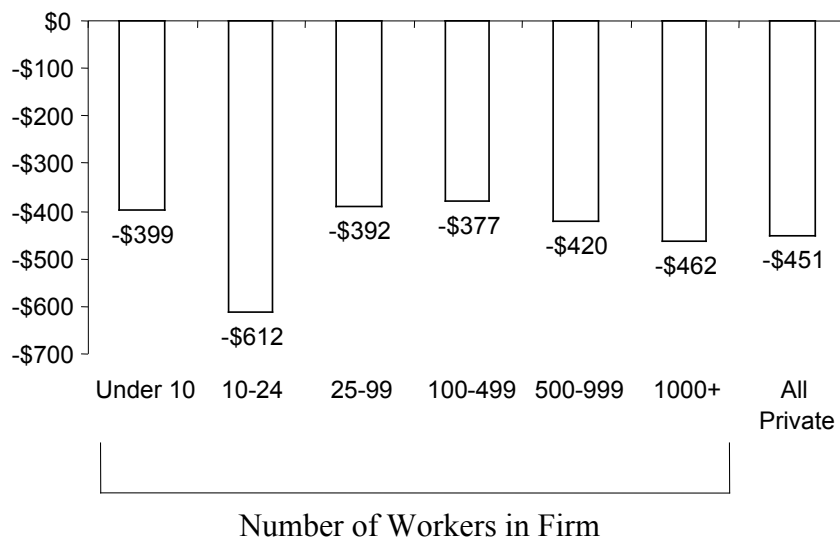
	Insuring	Non-insuring	Total
Private Employer Spending Under Current Policy			
Current			
Workers & Dependents	\$264.7	--	\$264.7
Retirees	\$19.5	--	\$19.5
Total	\$284.3	--	\$284.3
Private Employer Spending Under the Policy			
Policy			
Workers & Dependents	\$225.8	\$2.6	\$228.4
Retirees	\$20.3	--	\$20.3
Total	\$246.1	\$2.6	\$248.7
Net Change	(\$38.2)	\$2.6	(\$35.6)

Source: Lewin Group estimates using the Health Benefits Simulation Model

We estimate that there would be about 1.9 million workers and dependents in firms that would decide to provide coverage due to the program. The net cost of this coverage to these employers at the adjusted community rate would be about \$2.6 billion.

Thus, the net impact of the program would be a reduction in private employer spending of \$35.6 billion. The average savings for private employers would be about \$451 per worker in firms that currently sponsor coverage. *Figure 11* presents the average change in costs per worker (includes currently insured and uninsured workers) by firm size.

Figure 11
Average Change in Employer Health Spending per Worker
in Insuring Firms by Firm Size under the Authors' Proposal



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

8. Household Impacts

The primary effects of the authors' proposal on families would be to reduce family premium payments and out-of-pocket spending for health services. Premium payments would be reduced by about \$41.0 billion (**Figure 12**). This reflects premium payments for newly insured persons and Medicaid eligible persons, less the amount of premium subsidies received. Out-of-pocket spending would be reduced by about \$14.1 billion, primarily due to expanded coverage and cost sharing subsidies under the plan. The net impact of these provisions would be a reduction in family health spending of about \$55.1 billion (before wage effects).

As discussed above, the savings to employers under the program are expected to be passed-on to workers in the form of increased wages. This would increase family incomes by about \$26.6 billion after taxes. We count this increase in after-tax income as an offset to family health spending. Thus, when the wage effects are considered, health spending for households would be reduced by about \$81.7 billion under the program.

Figure 12
Impact of Authors' Proposal on Family Health Spending

	Without Wage Effects	With Wage Effects	With Income Tax Increase
Change in Premiums	(\$41.0)	(\$41.0)	(\$41.0)
Change in Out-of-pocket	(\$14.1)	(\$14.1)	(\$14.1)
After Tax Wage Effects a/	--	(\$26.6)	(\$26.6)
Income Tax to Fund Program	--	--	\$127.4
Net Change	(\$55.1)	(\$81.7)	\$45.7

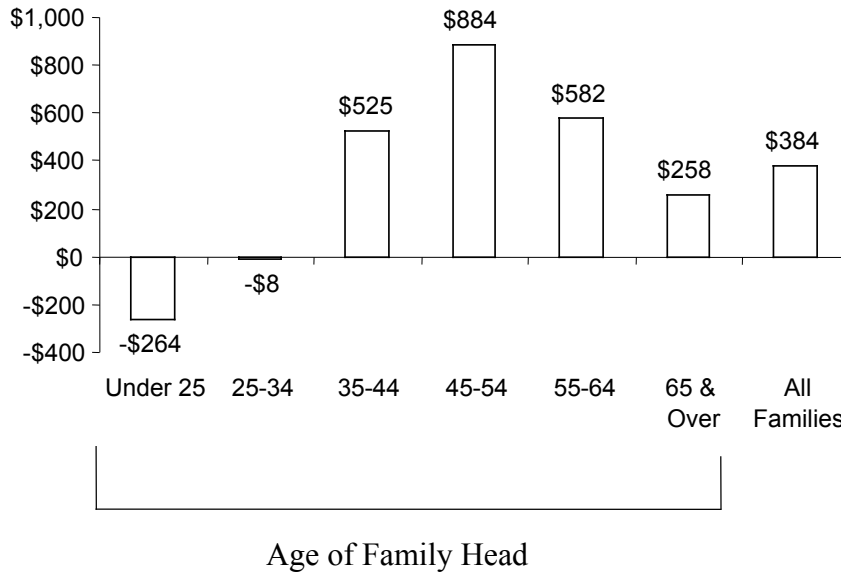
a/ The increase in after-tax wage income resulting from the program is counted here as an offset to family health spending

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

These savings would be more than offset by the increases in federal and state income taxes required to fund the program (\$127.4). When these taxes are added to family costs, the program increases family health spending by about \$45.7 billion. This is an average increase in family health spending of about \$384 per family (**Figure 13**).

Spending would on average increase across all age groups except families headed by someone under the age of 34 and 25, where costs would be reduced by an average of \$264 and \$8 per family, respectively. This reflects the fact that many of the families and individuals in this age group would qualify for subsidies but have low enough incomes that they would not be greatly affected by the income tax increase. Even families with a head age 65 or older would on average see an increase in spending, reflecting the fact these individuals are also affected by the income tax increase.

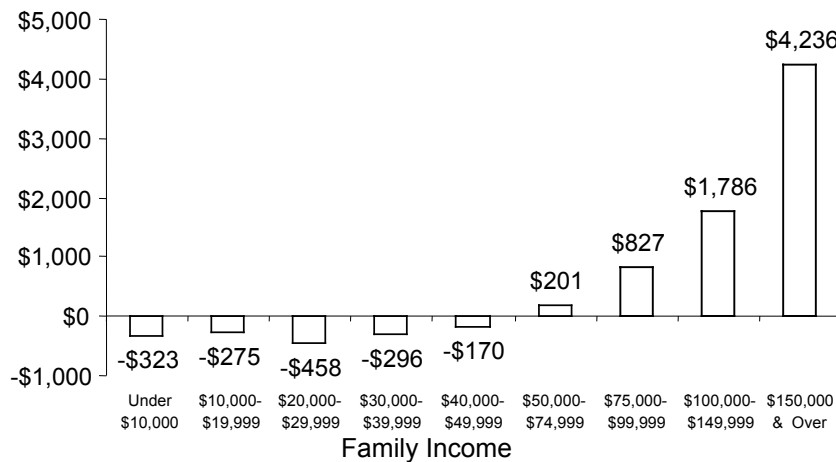
Figure 13
Change in Average Family Health Spending under the Authors' Proposal in 2002 by Age of Family Head a/



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

The program would result in a substantial transfer of income to lower-income families. For example, families with incomes of less than \$50,000 would see savings between \$170 per family and \$458 per family, while families with incomes over \$150,000 would see an average increase in health spending (i.e., including tax payments) of \$4,236 per family (*Figure 14*). This reflects the fact that subsidies under this proposal would go to lower-income persons while higher income persons would see the largest increases in taxes under the progressive structure of the income tax.

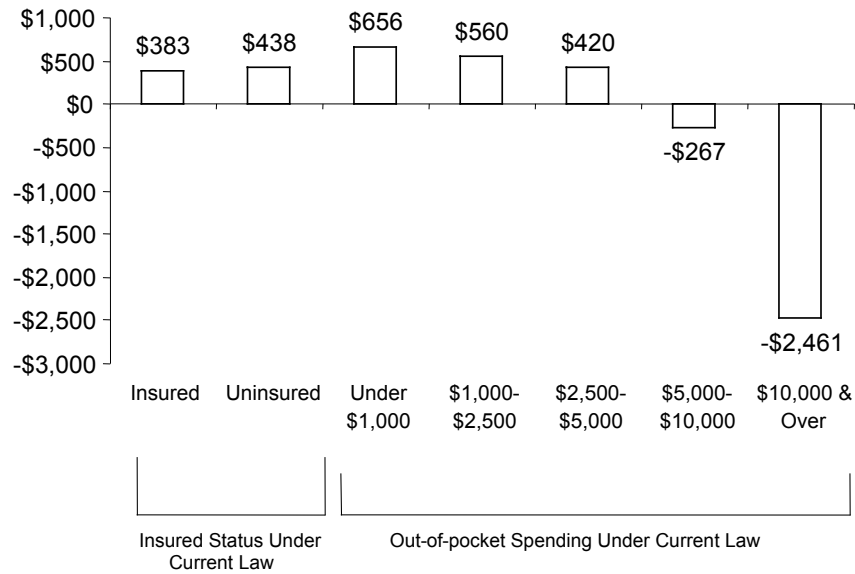
Figure 14
Change in Average Family Health Spending by Family Income



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

Figure 15 presents the average change in health spending per family by current insured status and family health spending under current law. **Figure 16** presents the distribution of newly insured persons by age and income.

Figure 15
Change in Average Family Health Spending by Current Insured Status



a/ Family spending under current law includes out-of-pocket spending for health services and family premium contributions.

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

Figure 16
Change in the Number of Uninsured

	Number of Uninsured under Current Law ^{a/}	Change in Number of Uninsured	Number Remaining Uninsured
Age			
Under 19	8,979	3,037	5,942
19-24	7,430	3,334	4,096
25-34	9,111	3,155	5,956
35-44	7,966	2,631	5,335
45-54	5,202	1,882	3,320
55-64	3,083	1,136	1,947
65 & Over	173	75	98
Family Income			
Under \$10,000	4,153	2,357	1,796
\$10,000-\$19,999	6,650	3,308	3,342
\$20,000-\$29,999	7,425	3,422	4,003
\$30,00-\$39,999	6,126	2,331	3,795
\$40,000-\$49,999	3,995	1,399	2,596
\$50,000-\$74,999	6,384	1,410	4,974
\$75,000-\$99,999	3,399	627	2,772
\$100,000-\$149,999	1,906	161	1,745
\$150,000 & over	1,906	235	1,671
Total	41,944	15,250	26,694

a/ Average monthly number of uninsured persons includes persons who are eligible for the current Medicaid/SCHIP program but have not enrolled.

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

9. Expenditures in Future Years

As discussed above, we estimate that national health spending would increase by about \$34.0 billion if the program were fully implemented in 2002. This is principally due to increased health services utilization among newly insured people, which we estimate would be partially offset by managed competition savings of about \$13.4 billion among currently insured people. These savings include the effect of requiring individuals in the public plan to pay the full cost of enrolling in a more costly health plan.

We also estimate that the increase in HMO enrollment resulting from the managed competition features of the program would slow the rate of growth in health spending in future years, resulting in savings for much of the affected population. The available research indicates that the rate of growth in health spending is reduced as the percentage of persons enrolled in HMOs increases. Based upon a review of these studies, we assume that each 10 percent increase in the number of persons enrolled in HMOs would result in a reduction in spending growth throughout the health care system of 1.3 percent for hospital services and 0.6 percent for physicians' services.

The Centers for Medicare and Medicaid Services (CMS) projects that national health spending will increase from about \$1.65 trillion in 2003 to about \$3.00 trillion in 2012

under current policy (*Figure 17*). Health spending would increase in 2003 to about \$1.67 trillion under the authors' proposal as newly insured people become covered. However, the rate of growth in health spending would be reduced due to the managed competition features of the program so that by 2007, total health spending under the author's proposal would be less than what it would be in that year under current law (i.e., without the expansion in coverage). The total net change in health spending over the ten-year period between 2003 through 2012 would be a net reduction of about \$363.5 billion.

Figure 17
National Health Spending under the Authors' Proposal 2003-2012
(in billions)

	Current Policy	Net Increase(Decrease)	Authors' Proposal
2003	\$1,653.4	\$18.5	\$1,671.9
2004	\$1,773.4	\$17.4	\$1,790.8
2005	\$1,902.2	\$14.8	\$1,917.0
2006	\$2,036.6	\$1.0	\$2,037.6
2007	\$2,174.9	(\$15.2)	\$2,159.7
2008	\$2,320.0	(\$33.1)	\$2,286.9
2009	\$2,476.1	(\$54.5)	\$2,421.6
2010	\$2,639.2	(\$77.4)	\$2,561.8
2011	\$2,815.8	(\$103.1)	\$2,712.7
2012	\$3,004.4	(\$131.9)	\$2,872.5

Source: Lewin Group estimates based upon "National Health Care Expenditure Projections: 2003-2012", by the Centers for Medicare and Medicaid Services (CMS), Office of the Actuary.

Total federal costs for subsidies under the authors' proposal would be \$139.9 billion in 2003, growing to \$277.1 billion by 2012 (*Figure 18*). This includes the cost of premium subsidies and the subsidies to higher-cost employers/individuals through the public plan (i.e., the amount by which public plan costs exceed premium revenues). These estimates reflect lags in enrollment for newly eligible persons in early years of the program as people learn of their potential eligibility for subsidies.¹⁶ They also reflect the impact of the managed competition features of the plan on the rate of growth in spending.

There would be several offsets to these new federal costs. New spending would be partly offset by the net reduction in federal Medicaid program costs under the proposal. There also would be an increase in income and payroll tax revenues due to the wage effect resulting from employer savings under the proposal. These include savings for employers of high-cost workers who obtain coverage in the public program at a lower cost (i.e., employer savings due to risk selection), and the reduced rate of growth in spending resulting from increased HMO enrollment.

¹⁶ We assume that there would be a lag in enrollment for persons newly eligible for subsidies. We assume that in the first year of the program, enrollment for newly eligible persons would be about half of the expected participation rate for the program. Enrollment in the second year for newly eligible is assumed to be equal to 80 percent of expected enrollment, with enrollment reaching 100 percent of its expected level in the third year and thereafter.

Figure 18
Federal Health Spending under the Authors' Proposal (in billions) a/

	Federal Subsidies b/	Medicaid Savings c/	Other Revenue Effects d/	Amount Needed to Fully Fund the Program
2003	\$139.9	\$15.1	\$15.7	\$109.1
2004	\$165.8	\$16.6	\$18.3	\$130.9
2005	\$188.3	\$18.5	\$21.0	\$148.8
2006	\$199.6	\$20.2	\$24.2	\$155.2
2007	\$211.0	\$22.2	\$27.5	\$161.3
2008	\$222.8	\$24.4	\$31.0	\$167.4
2009	\$235.4	\$26.7	\$34.9	\$173.8
2010	\$248.4	\$29.3	\$39.2	\$179.9
2011	\$262.4	\$32.1	\$43.9	\$186.4
2012	\$277.1	\$35.2	\$49.0	\$192.9

a/ Estimates reflect expected lags in enrollment for persons newly eligible for subsidies in the first two years of the program.

b/ Assumed to grow at the CMS estimate of growth in total acute care spending, reduced to reflect the impact of the managed competition features of the plan.

c/ Assumed to grow at the rates projected by CMS for the Medicaid program.

d/ Includes income and payroll tax revenues on increased wages for persons in firms with reduced health benefits costs. Reflects impact of subsidy to higher cost firms and reduced employer spending growth resulting from managed competition.

Source: Lewin Group estimates based upon "National Projections: 2003-2012," by the Centers for Medicare and Medicaid Services (CMS), Office of the Actuary.

D. Sensitivity to Key Assumptions

The estimates presented above are sensitive to the assumptions used in our analysis. At the request of the authors, we have estimated the cost and coverage impacts of their proposal under different assumptions. In this section, we present estimates for the authors' proposal under two alternative scenarios.

The first scenario assumes a higher level of take-up of insurance coverage for people who are eligible for subsidized coverage under the proposal. In the second scenario, we assume that savings under the managed competition provisions of the plan are higher than we have assumed.¹⁷

1. Higher Enrollment Scenario

In the Lewin Group estimates presented above, we estimated enrollment in the public plan for people who do not have access to employer coverage based upon a study of enrollment experience in the current Medicaid program and in other subsidized insurance programs in the country. These result in the following assumptions:

¹⁷ All other assumptions are assumed to remain the same as discussed above under both of these scenarios.

- Enrollment for people who qualify for full premium subsidies averages about 70 percent for uninsured people and about 45 percent for people who currently have coverage from some other source; and
- Based upon an analysis of programs requiring a premium contribution (i.e., the Minnesota Care program and the Washington basic health plan), we assume that enrollment declines by about 37 percent when a premium is required and that the enrollment level declines as the amount of the premium increases.

In this sensitivity case, we assume that the enrollment rate for uninsured people who qualify for full premium subsidies averages about 90 percent based upon take-up rates reported for a recent expansion in coverage in Massachusetts. We assume that participation rates are increased proportionately for those qualifying for only partially subsidized premiums.

Under the author's assumptions the number of uninsured people who would become insured would increase from the Lewin Group estimate of 15.2 million people to 24.8 million people. Thus, under the authors' assumption, about 60 percent of the 41.9 million people without insurance would become covered. *Figure 19* presents the changes in coverage that we estimate under these two sets of assumptions.

The increased program participation would increase our estimate of the number of people who enroll in the public plan by about 9.6 million people. The increased public program enrollment would increase the net cost of the public program from \$214 billion under the Lewin Group assumptions to about \$236.4 billion under the authors' assumptions (*Figure 20*). This is an increase in estimated program costs of about \$22.4 billion. This increase is due primarily to increased subsidy costs, since premiums and cost sharing for all of the additional people in the pool in our simulations would be at least partially subsidized.

Costs to the federal government net of offsets would increase from \$127.4 billion under the Lewin Group Assumptions to about \$143.7 billion using the authors' assumptions (*Figure 21*).

Figure 19
Coverage Transitions Under the Authors' Proposal
(in millions)

		Primary Sources of Coverage Under Proposal							
		Public Program		Private Coverage		Other Sources			
Lewin Assumptions									
Base Case Coverage	Total	Employer	Individual	Employer	Non-group	CHAMPUS	Medicare	Medicaid	Uninsured
Employer	162.1	81.0	0	81.1	0	0	0	0	0
Non-Group	11.2	0.0	5.2	0.5	5.4	0	0	0	0
CHAMPUS	3.5	0	0.4	0	0	3.1	0	0	0
Medicare	33.8	0	0	0	0	0	33.8	0	0
Medicaid	27.4	0	25.3	0	0	0	0	2.1	0
Uninsured	41.9	0.8	13.3	1.1	0	0	0	0	26.7
Total	279.9	81.8	44.2	82.7	5.4	3.1	33.8	2.1	26.7
Author's Assumptions									
Employer	162.1	81.0	0	81.1	0	0	0	0	0
Non-Group	11.2	0.0	5.2	0.5	5.4	0	0	0	0
CHAMPUS	3.5	0	0.4	0	0	3.1	0	0	0
Medicare	33.8	0	0	0	0	0	33.8	0	0
Medicaid	27.4	0	25.3	0	0	0	0	2.1	0
Uninsured	41.9	0.8	22.9	1.1	0	0	0	0	17.1
Total	279.9	81.8	53.8	82.7	5.4	3.1	33.8	2.1	17.1

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