Reconciling the CBO and Lewin Estimates on the Public Plan

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On July 27, 2009 we released a study of the July 14th draft of The American Affordable Health Choices Act of 2009, known as the "tri-committee bill," which includes a public plan that would compete with private insurance for enrollment.[1] We estimated that enrollment in the public plan under the tri-committee bill would reach 103.4 million people compared with the Congressional Budget Office (CBO) estimate of 11 to 12 million people. How could our estimates differ by a factor of 10?

There are two reasons for the difference in estimates for the bill. The first stems from the fact that the bill does not specify which size companies ultimately would be allowed to enter the exchange and thus the public plan. The bill requires that the exchange be open to individuals and small firms with less than 20 workers by the second year of the program and gives a newly established "Commissioner" the authority to extend eligibility to all employers in subsequent years.

The CBO assumed that the plan would be open to only individuals and firms with fewer than 50 workers by the third year of the program, which includes only about 30 percent of all Americans that now have employer health insurance. We dealt with the ambiguity in the legislation by providing estimates under two alternative assumptions. We showed that if the exchange is opened to individuals and firms with fewer than 20 workers only, public plan enrollment would reach about 33.6 million people (***Figure 1***). We estimated that enrollment would grow to 103.4 million people if opened to all firms.

> These estimates apply to the tri-committee bill where the public plan is would pay health care providers at Medicare payment levels, (plus 5 percent for physicians), which are up to 30 percent less than what private insurers pay. This feature is included in the versions of the bill latter passed by the Ways and Means and Education and Labor Committees.
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> The version latter passed by the Energy and Commerce (E&C) Committee requires the public plan to pay providers at negotiated rates, which are similar to what private plans pay. Consequently, we estimate that only about 20 million people would enroll in the public plan under the E&C bill. See: John Sheils and Randy Haught, "Long-Term Cost of the American Affordable Health Choices Act of 2009; As Amended by the Energy and Commerce Committee In August 2009," (report to the Peter G Peterson Foundation) The Lewin group, September 9, 2009.

If we use the CBO assumption that the exchange is open only to individuals and firms with fewer than 50 workers, we estimate public plan enrollment would be about 42.7 million people. Thus, our enrollment estimates are about four times the CBO estimate when we assume the same levels of eligibility for the public plan.

The second area of difference is over premium levels in the public plan. The CBO assumes that premiums in the public plan would be 10 percent less than for comparable private insurance while we estimate savings of 23 percent. When we use the CBO assumption of only a 10 percent premium differential, we show that about 22.1 million people would enroll in the public plan vs. the 11 million to 12 million people estimated by the CBO.

[1] John Sheils and Randy Haught, "Cost and Coverage Impacts of the American Affordable Health Choices Act of 2009: the July 15th draft," Staff Working Paper # 8, The Lewin Group, July 27, 2009.

Figure 1
Estimated Enrollment in the Public Plan under Alternative Premium Differential Assumptions (millions)

Estimated Public Plan Premium Savings of 20% to 25%		
Firms Eligible	Lewin Estimate	CBO Estimate
Individuals and Firms with Fewer than 20 Workers	33.6	--
Individuals and Firms with Fewer than 50 Workers	42.7	--
Individuals and All Firms	103.4	--
Assuming Public Plan Premium Savings of 10%		
Individuals and Firms with Fewer than 50 Workers	22.1	11.0-12.0

Source: Lewin Group estimates using the Health Benefits Simulation model; and Congressional Budget Office (CBO), Letter to Charles Rangel, Chairman Committee on Ways and Means, U.S. House of Representatives, July 14, 2009

It appears that the CBO estimates only a 10 percent price differential because they assume that private plans would be able to lower their costs enough to remain competitive with the public plan. They point out that health plan bids to cover Medicare beneficiaries under the Medicare Advantage (MA) program are typically 102 percent of Medicare fee-for-service (FFS) costs in their geographic area (98 percent for HMOs).[2]

The MA experience actually demonstrates that private health plans can not compete with the Medicare FFS program, at least not without subsidies or some other type of overpayment. For example, prior to 2000, health plans under the Medicare +Choice program were paid about 5 percent more than Medicare FFS costs for the people they covered. Congress responded by adopting a risk-adjustment system to bring plan payments into line with true FFS costs for the enrolled population. This combined with BBA provider payment reductions caused many plans to leave the program and enrollment fell by 25 percent (***Figure 2***).

To salvage the program, Congress created Medicare Advantage in 2003 and deliberately set health plan payments levels according to a Benchmark rate that is 12 percent to 15 percent more than expected costs for these beneficiaries under the FFS Medicare program. Plans were to use these overpayments (i.e., benchmark rate less FFS bid) to provide additional benefits, as an inducement for Medicare beneficiaries to participate.[3] In fact, the CBO has estimated that if these overpayments are eliminated, MA enrollment would fall by about half. This seems to demonstrate that private plans would find it difficult to compete with a FFS plan paying Medicare rates.

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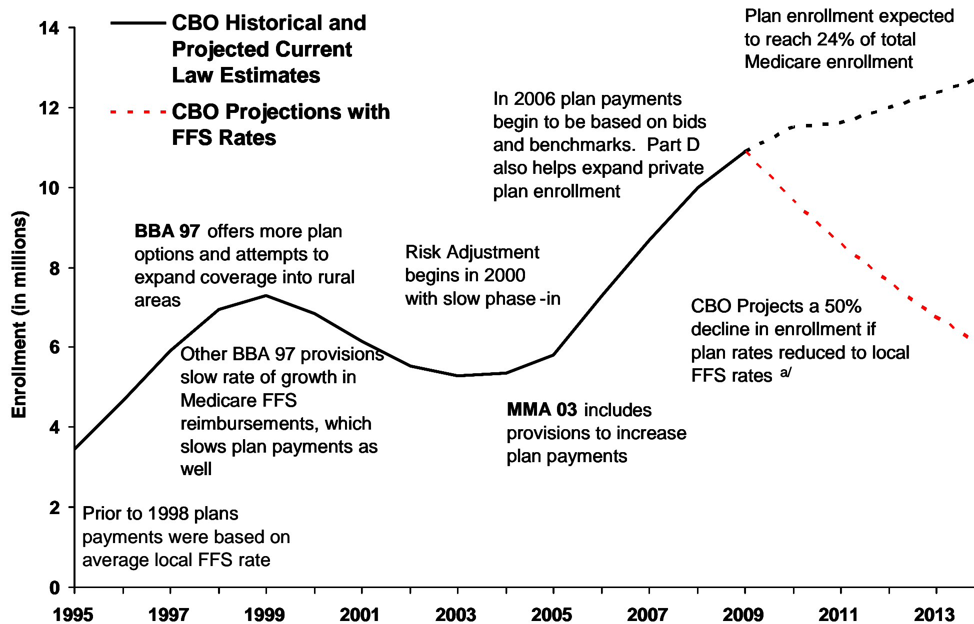
[2] Our premium differential estimate is adjusted for adverse selection into the public plan which we estimated to be a factor of about 12 percent.

[3] Plans submit bids based upon their cost of providing the Medicare FFS benefits, which have been about 102 percent to 105 percent of the FFS cost. Plans receive 75 percent of the difference between the benchmark rate and their bid amount, which they are required to use to provide additional benefits.

Figure 2
Enrollment of Medicare Beneficiaries in Private Health Plans for Medicare



[a/] Statement of Peter Orzag. April 11, 2007. *The Medicare Advantage Program: Enrollment Trends and Budgetary Effects.*

The fact that the MA FFS plan bids are equal to about 102 percent of FFS Medicare costs stems from the unique bargaining leverage that health plans have with providers for the Medicare population. Plans are able to recruit health care providers for their MA networks by offering payment levels that are up to 5 percent greater than the Medicare FFS payment levels. Providers see this as a good deal since the alternative would be to treat these patients at Medicare FFS payment levels. This is a kind of bargaining leverage that would not be replicated for the non-Medicare population unless the public plan has a very large market-share, just as Medicare now has with the aged population.

It has been suggested that health plans could compete with the public plan by "negotiating harder" with providers. While forming stronger provider networks can reduce premiums, it can also discourage enrollment. Networks can control costs only if enrollees can be directed to use these selected providers. Consumers experience this as limitations on access such as higher co-payments for using out-of-network providers. Thus, while increased selective contracting can reduce health plan premiums, it can also alienate potential enrollees, leading to a loss of market share.

For these reasons, it is unlikely that increased selective contracting would enable health plans to maintain market share when competing with a public plan paying Medicare FFS payment levels. Also, if physician participation in the public plan is as high as it is under the current Medicare program, the public plan is likely to include more providers than are included in many private health plan networks.