



## The Cost and Coverage Impacts of a Public Plan

Testimony before the Ways and Means Committee

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## About The Lewin Group

The Lewin Group is a health care and human services policy research and management consulting firm. We have over 25 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 options. In keeping with our tradition of objectivity, The Lewin Group is not an advocate for or against any legislation. The Lewin Group is part of Ingenix, Inc., which is a wholly owned subsidiary of the UnitedHealth Group. To assure the independence of its work, The Lewin Group has editorial control over all of its work products.

## The Cost and Coverage Impacts of a Public Plan

Thank you for this opportunity to address the committee on the coverage effects of a public plan. I am a Vice-president with The Lewin Group with 25 years experience in studying and analyzing proposals to reform health care and extend health insurance to the uninsured. We are committed to providing independent, objective and non-partisan analyses of policy proposals. The Lewin Group does not advocate for or against legislative proposals.

President Obama and Senator Baucus have proposed to create an “exchange” offering individuals and employers a selection of health plans. They also propose to create a new “public plan” that would compete for enrollment with private insurance plans in the exchange. Premiums under the public plan would be up to 30 percent less than private insurance plans if Medicare payment levels are used. Due to this substantial cost advantage, we estimate that up to 119.1 million of the 171.6 million people who now have private employer or non-group coverage would move to the public plan (70 percent).

Although the details of these proposals are still being developed, President Obama’s health reform proposal from the 2008 presidential campaign states:

*“The new public plan will be open to individuals without access to group coverage through their workplace or current programs. It will also be available to people who are self-employed and small businesses that want to offer insurance to their employees.”<sup>1</sup>*

The white paper on health reform developed by Senator Baucus would:

*Create an exchange “through which individuals and small businesses in the market for insurance could obtain affordable health care coverage” and states that “the exchange would also include a new public plan option, similar to Medicare.”<sup>2</sup>*

Also, the Commonwealth Fund reform proposal would eventually allow employers of all sizes to purchase coverage in the public plan for their workers.<sup>3</sup>

To assist in designing the public plan, we developed estimates of the number of people enrolling in the plan under alternative design features. We estimated the effect of varying eligibility by firm size and provider payment levels under the program, which at this time seem to be the key design features.

Our estimates and methodology and results are presented in the following sections:

- Features of the public plan;
- Premiums in the public plan;

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<sup>1</sup> “Barack Obama’s Plan for a Healthy America: Lowering health care costs and ensuring affordable, high-quality health care for all.”

<sup>2</sup> “Call to Action: Health Reform 2009,” U.S. Senator Max Baucus, Chairman, Senate Finance Committee.

<sup>3</sup> “The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way,” The Commonwealth Fund Commission on a High Performance Health System, February 2009

- Coverage effects;
- Employer Coverage;
- Provider impacts; and
- Cost-Shifting.

## Features of the Public Plan

The public plan has been proposed as part of broad health reform proposals that would substantially expand insurance coverage. For illustrative purposes, we assume that the public plan would be implemented as part of a health reform program that includes coverage expansions similar to those proposed by President Obama in the 2008 campaign. Key elements of the President's proposal include:<sup>4</sup>

- There would be a mandate for children to have coverage;
- Medicaid eligibility is expanded to include all adults living below 150 percent of the Federal Poverty Level (FPL), including able-bodied adults without custodial responsibilities for children;
- Tax credits are provided to people purchasing private insurance who live between 150 percent and 400 percent of the FPL;
- Medical underwriting and health status rating is eliminated in all insurance markets, but rating by age is permitted;
- Medium and large employers are required to offer insurance or pay a payroll tax; and
- Tax credits are provided to small employers (fewer than 10 workers) with low-wage workers for up to 50 percent of employer spending for worker coverage.

We assume that the benefits provided under the public plan are the same as those offered under the BlueCross/Blue Shield Standard Option offered to members of Congress and federal workers under the Federal Employees Health Benefits Plan (FEHBP) (as proposed by President Obama). These benefits include hospital care, physician services, prescription drugs, substance abuse, mental health services and dental care. For in-network utilization, there is a \$15 copayment for office visits with no deductible. The plan includes a \$250 deductible and higher copayments for out-of-network utilization, up to a maximum out-of-pocket limit amount of \$4,000.

We used The Lewin Group Health Benefits Simulation Model (HBSM) to simulate the effect of such a program on coverage.<sup>5</sup>

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<sup>4</sup> "McCain and Obama Health Care Policies: Cost and Coverage Compared," The Lewin Group, October 8, 2008.

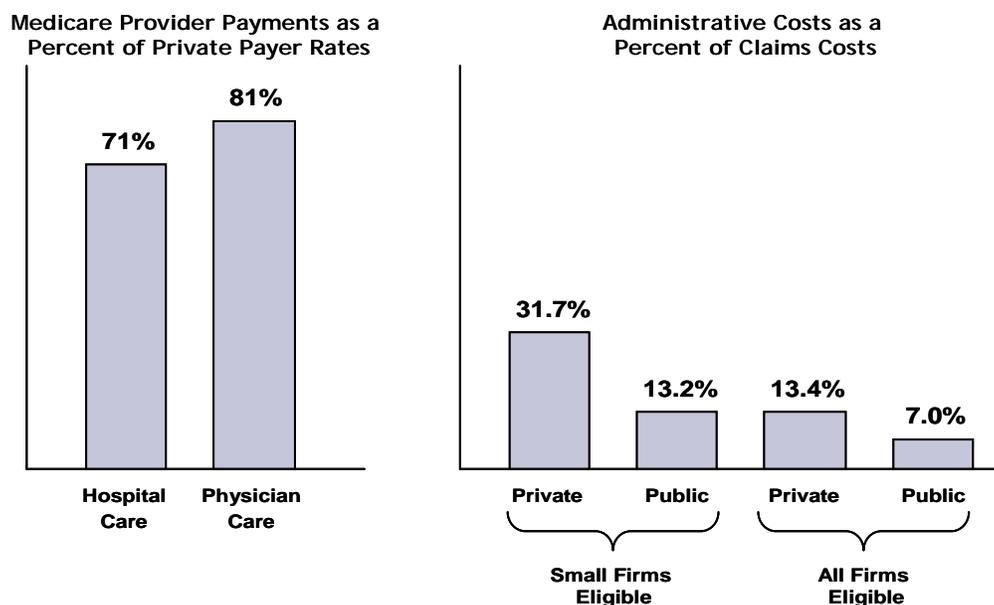
<sup>5</sup> "The Health Benefits Simulation Model (HBSM): Methodology and Assumptions," The Lewin Group, February 19, 2009.

## Premiums in the Public Plan

For illustrative purposes, we begin the analysis by estimating the effect of creating a new public plan modeled on Medicare that is available to individuals and the self-employed. We began by estimating the effect of the plan assuming that it would use Medicare provider reimbursement levels. We then estimated enrollment and costs assuming enrollment is limited to small firms and under alternative provider reimbursement assumptions.

We estimate that premiums for the public plan under this scenario would be roughly 30 percent less than premiums for comparable private coverage (effects vary by firm size). As shown in *Figure 1*, provider payment levels for hospital services under Medicare are equal to only about 71 percent of what is paid by private health plans for the same services. In fact, Medicare payments to hospitals are actually equal to only between 92 percent and 95 percent of the cost of the services provided by hospitals.<sup>6</sup> For physician services, Medicare pays only about 81 percent of what is paid by private health plans for the same services.<sup>7</sup>

**Figure 1**  
Benefits and Administrative Costs under a Medicare-based Public Plan and Private Insurance  
Compared: 2010



Source: American Hospital Association, "Trends Affecting Hospitals and Health Systems," TrendWatch Chartbook April 2008; "Report to Congress: Medicare Payment Policy," Medicare Payment Advisory Commission (MedPAC), March 2008; and State Health Facts, The Kaiser Family Foundations (KFF), 2003 report.

Administrative costs are also expected to be lower for the public plan than under private insurance, reflecting that the public plan would not include an allowance for insurer profit and insurance agent and broker commissions and fees. Administrative costs, including profit and

<sup>6</sup> American Hospital Association, "Trends Affecting Hospitals and Health Systems," TrendWatch Chartbook, April 2008.

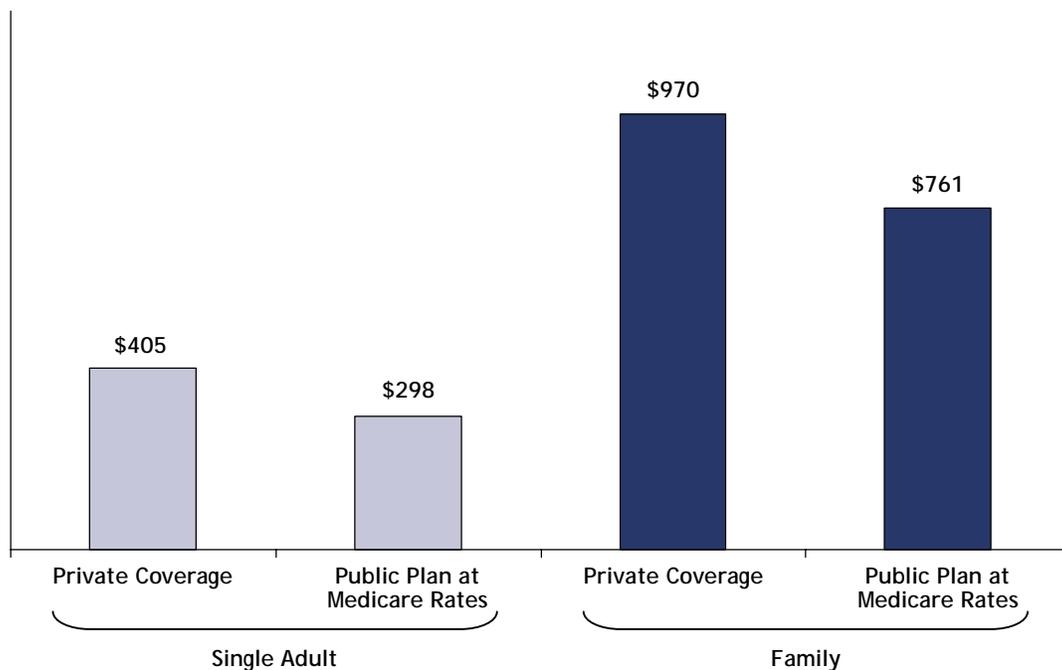
<sup>7</sup> State Health Facts, The Kaiser Family Foundations (KFF), 2003 report.

commissions, for privately insured firms are on average equal to about 13.4 percent of covered benefits. If implemented through Medicare, administrative costs would be equal to about 7.0 percent of covered services.

Our estimate of administrative costs is based upon a detailed analysis of administrative costs under insurance pools which we present in our model documentation.<sup>8</sup> These administrative costs are about twice what administrative costs currently are in the Medicare program (about 6.5 percent of benefits). Costs will be higher in the public plan than in Medicare because the program will need to process the movement of individuals across health plans when people decide to change their source of coverage. The plan will also need to collect premiums from individuals and employers who decide to enroll. These functions are not required for the current Medicare populations once enrolled.

*Figure 2* presents our estimates of the average cost of insurance for individuals in the public plan and in the private insurance markets. Premiums for family coverage under the public plan would average \$761 per month compared with \$970 per month in the current private insurance market.

**Figure 2**  
Impact of Using Medicare Provider Payment Rates on Premiums in the Public Plan in 2010



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

<sup>8</sup> "The Health Benefits Simulation Model (HBSM): Methodology and Assumptions," The Lewin Group, February 19, 2009.

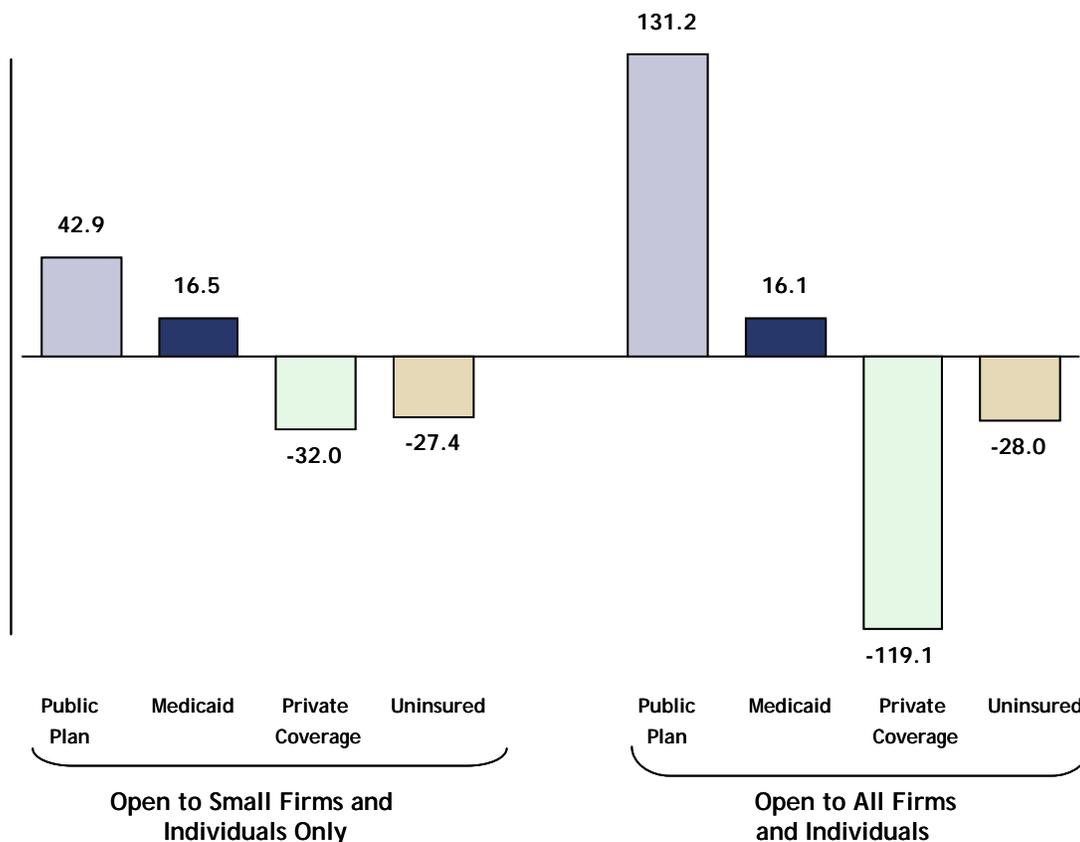
## Coverage Effects

We estimate that the Obama-like health reform program described above would reduce the number of uninsured by about 28 million people. This reflects expanded eligibility under Medicaid/CHIP, and the tax credits under the proposal.

As discussed above, the President's campaign proposal would limit enrollment to individuals, the self-employed and small employers. Large employers would not be permitted to cover their workers through the public plan. Under this scenario, about 42.9 million people would be enrolled in the public plan (*Figure 3*). The number of people with private coverage would fall by about 32.0 million people.

If we assume that the public plan is open to all individuals, the self-employed and all firms, the public plan would enroll about 131.2 million people (includes some uninsured who become covered). The number of people with private health insurance would decline by about 119.1 million people (*Figure 3*). This is equal to about 70 percent of all people currently covered under private health insurance (excludes supplemental coverage for Medicare beneficiaries).

**Figure 3**  
Public Plan Enrollment and Reduction in Private Coverage under a Public Plan Using Medicare Payment Levels 2010 (millions) <sup>a/</sup>



a/ Changes in coverage under Medicaid and other programs not shown.

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

The impact of the program on private coverage would depend largely on the levels of reimbursement under the program. While Medicare payment levels have been proposed, it would be possible to pay providers at other levels. To illustrate, we estimated the number of people enrolling in the public plan under two alternative payment level assumptions.

If the program is implemented using private payer rates (i.e., “negotiated” rates), premiums under the public plan would be only 6 percent to 9 percent less than in private plans, reflecting that the program would still have lower levels of administrative costs than private insurance. Public plan enrollment, assuming all firms are eligible to enroll, would fall from 131.2 million people with Medicare reimbursement levels to about 20.6 million people at private payer levels (*Figure 4*). We also show enrollment assuming payments are set at the midpoint between Medicare and private payment levels.

**Figure 4**  
Enrollment in Public Plan Under Alternative Public Plan Scenarios

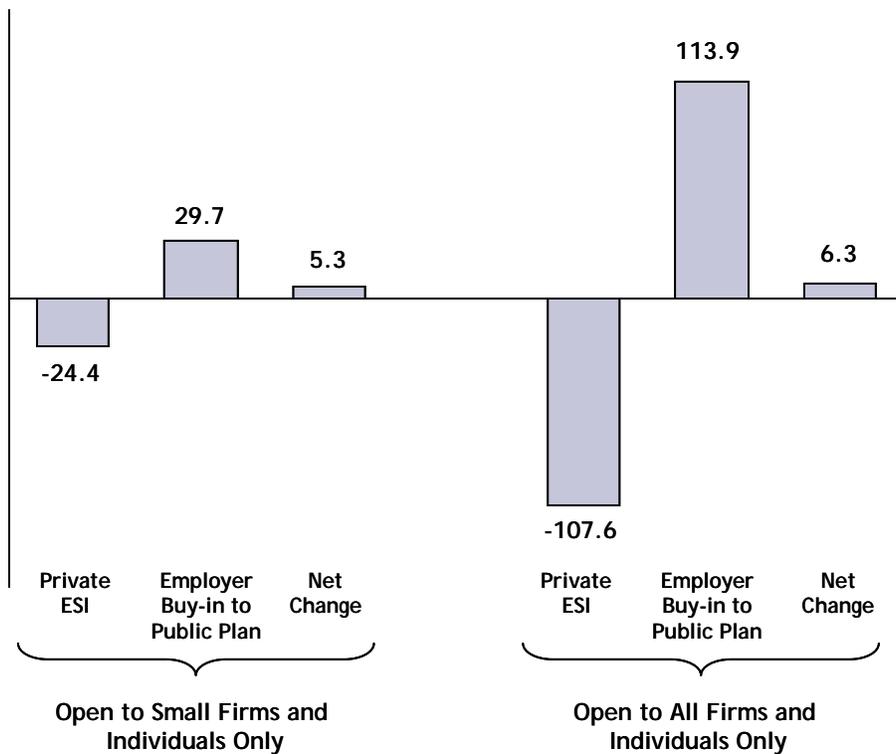
	Eligible Groups					
	Small Firms, Self-employed and Individuals Only			All Firms, Self-employed and Individuals		
	Private Payer Levels	Midpoint Payment Levels	Medicare Payment Levels	Private Payer Levels	Midpoint Payment Levels	Medicare Payment Levels
Public Plan Premiums as Percent of Private	-9% to -11%	-15% to -30%	-25% to -40%	-6% to -9%	-12% to -24%	-25% to -32%
<b>Coverage Effects (millions)</b>						
Reduction in Uninsured	23.8	26.1	27.4	25.1	26.7	28.2
Enrollment in National Public Plan	17.0	31.5	42.9	20.6	77.5	131.2
Change in Private Coverage	910.4	-21.5	-32.0	-12.5	-67.5	-119.1

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

## Employer Coverage

We estimate there will be about 157.4 million people with private employer-sponsored Insurance (ESI) in 2010 including workers, dependents and retirees. These include both private employer and government worker programs. In *Figure 5*, we present our estimates of the changes in the number of workers and dependents where the employer contributes to the health insurance premiums.

**Figure 5**  
**Changes in Employer Participation in Worker Coverage Using Medicaid Payment Levels**  
**in Public Plan (millions) <sup>a/</sup>**



a/ Assumes employers are required to either provide insurance or pay a 6 percent payroll tax.  
 Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

We estimate that if all firms are permitted to buy coverage for their workers through the public plan assuming Medicare payment levels, about 107.6 million workers and dependents would lose the private employer coverage they now have. However, employers would pay the premium for coverage under the public plan for about 113.9 million people. This would result in a net increase in the number of workers and dependents where the employer is contributing to the cost of insurance of about 6.3 million people. These include primarily workers in firms where the employer decides to cover their workers under the public plan rather than pay the payroll tax.

*Figure 6* presents the impact of the proposal on employer participation in worker health benefits under alternative design scenarios.

**Figure 6**  
**Changes in Employer-Sponsored Insurance (ESI) under Alternative Public Plan Scenarios (thousands)**

	Eligible Groups					
	Small Firms, Self-employed and Individuals Only			All Firms, Self-employed and Individuals		
	Private Payer Levels	Midpoint Payment Levels	Medicare Payment Levels	Private Payer Levels	Midpoint Payment Levels	Medicare Payment Levels
Currently with Employer Coverage	157,448	157,448	157,448	157,448	157,448	157,448
<b>Changes In Employer-sponsored Insurance (thousands)</b>						
Change Private ESI	(6,732)	(13,917)	(24,417)	(10,120)	(59,917)	(107,617)
Employer Pays Public Plan Premium	8,905	18,553	29,667	12,732	65,259	113,948
Changes in Employer Participation in Coverage	2,173	4,636	5,250	2,612	5,342	6,331

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

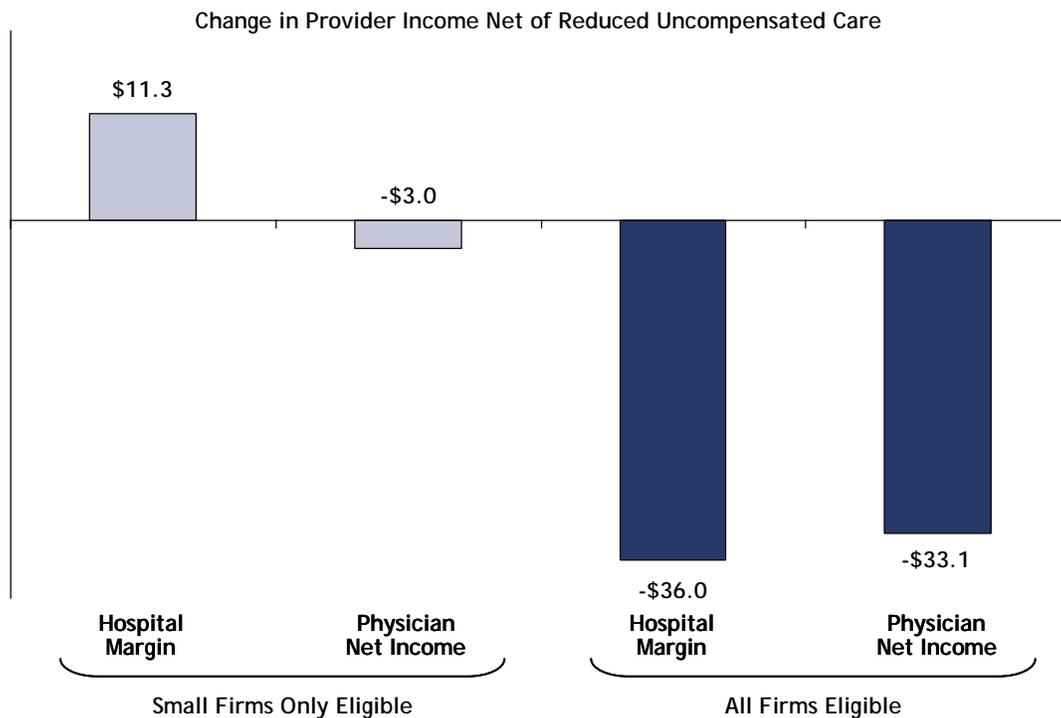
## Provider Impacts

The program would have a significant impact on provider net incomes. Expanding coverage would reduce uncompensated care for uninsured people and would result in increased health services utilization for the newly insured, all of which would represent new revenues to providers. These increases in revenues would be largely offset by reductions in payment levels for people who shift from private insurance to the public plan and the provider's cost of providing additional care to the newly insured.

Assuming the public plan is open to all individuals and all employers, total hospital margin would fall by \$36.0 billion in 2010 (*Figure 7*). This is equal to about 4.6 percent of total hospital net revenues (i.e., gross revenues less contractual allowances) in that year. Physician net income would fall by about \$33.1 billion, which is equal to about 6.8 percent of physician revenues. Thus, under this scenario, health care providers are providing more care for more people with less revenue.

The effect on provider income is substantially smaller under a scenario where large firms are excluded from participation in the public plan. For example, hospital margin would actually increase by \$11.3 billion in 2010, assuming the plan is limited to only individuals, the self-employed and small firms. Thus, the increased revenues for newly insured people (including reduced uncompensated care) are greater than the loss of revenues for people who would become covered under the public plan. Physician income net of practice expenses would fall by \$3.0 billion under this scenario.

**Figure 7**  
**Impact of Public Plan on Provider Income if Medicare Provider Payment Rates Used**



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

In *Figure 8*, we present estimates of the impact of the program on provider incomes under alternative payment level assumptions for the public plan.

**Figure 8**  
**Impact on Hospital and Physician Net Income in 2010 (billions)**

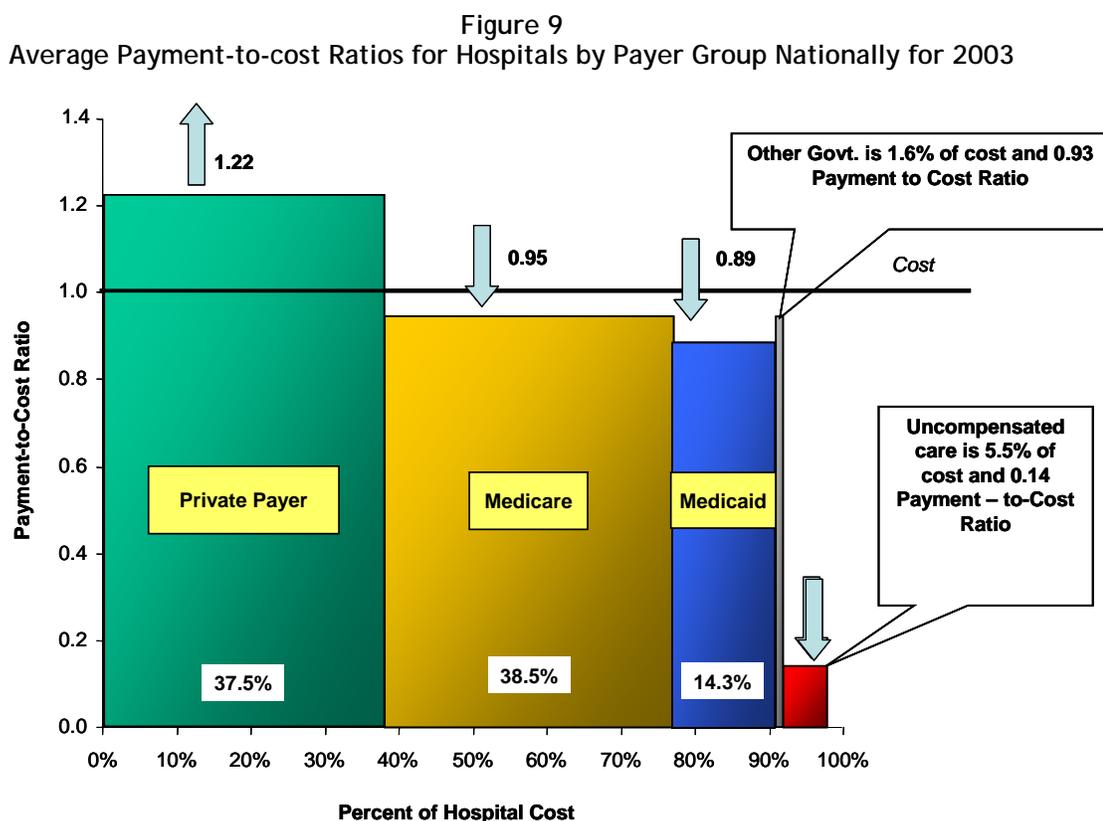
	Hospital Income		Physician Income	
	Small Firms Only	All Firms Eligible	Small Firms Only	All Firms Eligible
<b>Assuming Medicare Payment Levels</b>				
Payment Level Reduction	-\$10.7	-\$58.0	-\$6.0	-\$36.1
Payments for Previously Uncompensated Care	\$22.0	\$22.0	\$3.0	\$3.0
Net Change	\$11.3	-\$36.0	-\$3.0	-\$33.1
Change as a Percent of Total Revenue	1.0%	-4.6%	-1.6%	-6.8%
<b>Assuming Midpoint Payment Levels (i.e., between Medicare and Private Payer Rates)</b>				
Payment Level Reduction	-\$6.1	-\$29.3	-\$4.8	-\$19.8
Payments for Previously Uncompensated Care	\$22.0	\$22.0	\$3.0	\$3.0
Net Change	\$15.9	-\$7.3	-\$1.8	-\$16.8
Change as a Percent of Total Revenue	2.0%	0.9%	-0.5%	-3.1%

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

## Cost-Shifting

Provider payments under private insurance are inflated to cover uncompensated costs for the uninsured and underpayments for services under public programs. This added cost to the privately insured is known as the cost-shift. For example, *Figure 9* depicts hospital payments for various payer groups. In 2003, Medicare payments were equal to only about 95 percent of the cost of the care provided. Hospital payments under Medicaid were equal to 89 percent of costs and payments by the uninsured were equal to about 14 percent of the cost of their care.

To compensate for these shortfalls in payment, hospitals typically charge higher amounts to privately insured patients. In 2003, payments for privately insured people were equal to about 122 percent of costs. Thus, payments under private insurance are inflated by the cost of covering uncompensated care and payment shortfalls under public health coverage programs.



Source: Al Dobson, Joan DaVanzo and Namrata Sen, "The Cost-Shift Payment 'Hydraulic': Foundation, History, and Implications," *Health Affairs*, January/February 2006, volume 25, number 1.

Data provided by MedPAC show that as the growth in provider payments under public programs is slowed, provider payments under private insurance increase. For example, Medicare hospital payment levels declined from 95 percent of costs in 2003 to 91 percent of costs in 2007. At the same time, private payer rates increased from 122 percent of costs in 2003 to about 132 percent of costs in 2007.

Not all of the shortfalls in payments are shifted to private insurers. The literature indicates that only about 40 percent of uncompensated care and payment shortfalls are passed-on as higher

prices for the privately insured. The remainder (60 percent) appears to be absorbed through reductions in costs and net income. Similar effects also have been observed for physician care. The evidence on cost-shifting includes:

- There are two separate studies indicating that about one-half of hospital payment shortfalls are passed on to private payers in the form of higher charges.<sup>9</sup> Two other studies showed considerably less evidence of hospital cost-shifting, although they did not rule out a partial cost-shift.<sup>10</sup>
- One study of physician pricing by Thomas Rice et al., showed that for each one percent reduction in physician payments under public programs, private sector prices increased by 0.2 percent.<sup>11</sup>
- Our own analysis of hospital data indicates that about 40 percent of the increase in 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.<sup>12</sup>

Based upon this evidence, we estimate that increasing the number of people covered under Medicare will increase the cost-shift for people who remain uninsured. This increase would be partly offset by reduced uncompensated care resulting from the expansion in coverage under the Obama proposal (28 million uninsured become covered under the proposal). Using existing research, we assume that 40 percent of the net reduction in provider payments would be passed back to private payers through the cost-shift.

Using these assumptions, we estimated the change in the cost-shift for each of the six scenarios presented above. The cost-shift would increase by about \$526 per privately insured individual the scenario where Medicare payment rates are used and firms of all sizes are permitted to enroll their workers in the public plan (*Figure 10*).

These cost-shift assumptions are highly speculative, however. For example, the health plans most likely to survive in a system dominated by the Medicare plan are likely to be integrated delivery systems such as HMOs. Many of these systems have their own hospitals and would be able to avoid cost-shifting, because they serve only those enrolled in their plan. Thus, it is difficult to be sure of the extent of cost-shifting with the public plan.

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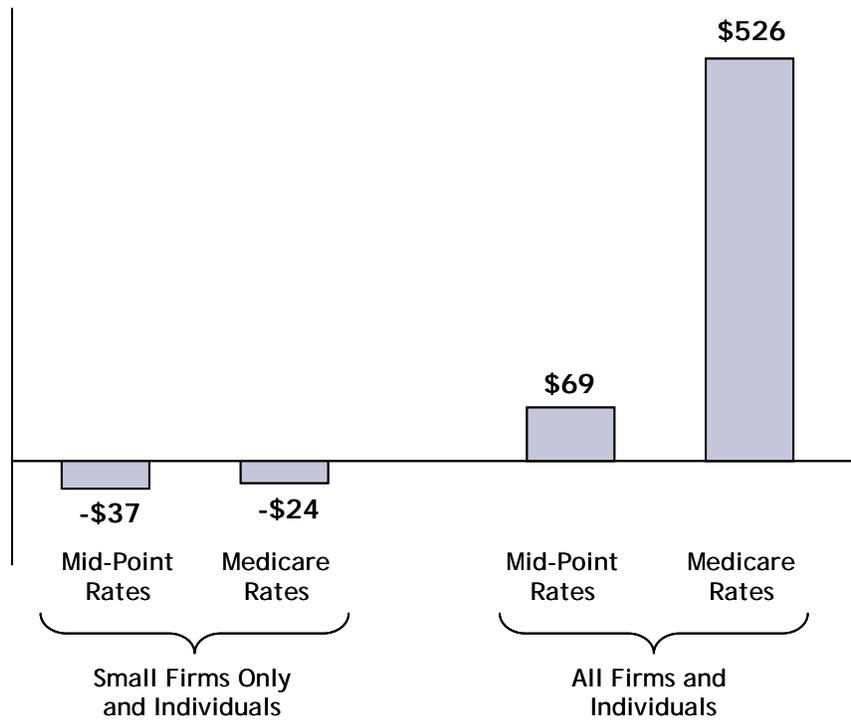
<sup>9</sup> Dranove, David, "Pricing by Non-Profit Institutions: The Case of Hospital Cost-Shifting," *Journal of Health Economics*, Vol. 7, No. 1 (March 1998); and Sloan, Frank and Becker, Edward, "Cross-Subsidies and Payment for Hospital Care," *Journal of Health Politics, Policy and Law*, vol. 8., No. 4 (Winter 1984)

<sup>10</sup> 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)

<sup>11</sup> Rice, Thomas, et al., "Physician Response to Medicare Payment Reductions: Impacts on public and Private Sectors," Robert Wood Johnson Grant No. 20038, September 1994.

<sup>12</sup> 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

Figure 10  
 Change in Cost-Shift per Privately Insured Person under Alternative Public Plan Scenarios



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