



July 28, 2009

To: Interested Parties

From: Center for Health Policy Studies, The Heritage Foundation

Re: The Impact of the American Affordable Health Choices Act of 2009

The Heritage Foundation commissioned [The Lewin Group](#), a highly respected health care policy and management consulting firm, to examine the impact of the American Affordable Health Choices Act of 2009 (H.R. 3200). Among other provisions, the bill would create a new public plan, modeled on Medicare, to compete with private health plans in a newly established health insurance exchange. In addition to national results, Lewin produced state level impacts of the draft legislation for a select group of states: Maine, Virginia, New Mexico, Montana, Nebraska, and Pennsylvania.

In its analysis, Lewin presents data estimating the impact of the bill, assuming eligibility to the exchange is open to all employers beginning in year three, on sources of coverage and potential changes in physician and hospital incomes. The highlights of the national report include:

Effects on Private Coverage and the Uninsured

- **48 percent of privately insured Americans would transition out of private insurance.** Of the estimated 172.5 million people with private health insurance, there would be a decline of 83.4 million people with private coverage.
- **56 percent of Americans with employer-based coverage would lose their current insurance.** Of the estimated 158.1 million Americans with employer-based coverage, 88.1 million people would be shifted out of their current employer-based plan.
- **80 percent of Americans in a health insurance exchange would end up in the public plan.** Of the estimated 129.6 million people who would obtain coverage through an exchange, 103.4 million people would be covered by the public plan.
- **34 percent of the uninsured in America would still lack coverage.** Of the estimated 49.1 million people without health insurance, the legislation would only reduce the uninsured by 32.6 million people, leaving 16.5 million people without coverage.

Effects on Physicians and Hospitals

- **Physicians would see their payment levels decline by \$31.7 billion as a consequence of the new public plan.** While physician net income may increase under the bill primarily due to other Medicare changes, a public plan with Medicare-based payments would lower reimbursements. Today, Medicare physician payments are, on average, 81 percent of private payments.
- **Hospitals could see their net annual income fall by \$61.9 billion, which roughly eliminates hospital total margins.** This significant loss in hospital income is also overwhelmingly attributable to the public plan using Medicare-based payments. Today, Medicare hospital payments are, on average, 68 percent of private payments.

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memorandum

July 17, 2009

Revised July 23, 2009

To: Stuart Butler

From: John Sheils and Randy Haught

RE: Analysis of the July 15 draft of The American Affordable Health Choices Act of 2009

The American Affordable Health Choices Act of 2009 would require all Americans to have health insurance. To assure access to affordable coverage, the bill expands the Medicaid program to cover all adults with incomes below 133 percent of the federal poverty level (FPL) (\$29,300 for a family of four), and provides premium subsidies for people living between 133 percent and 400 percent of the FPL (i.e., \$88,000 for a family of four). It also requires most employers to contribute to the cost of coverage for their workers.

The bill also establishes an “exchange” that presents a selection of health coverage alternatives including a newly created public plan that would compete with private insurers for enrollment. Insurance markets are reformed to assure guaranteed issue of coverage to all applicants regardless of health status. Also, insurers would be prohibited from charging higher premiums on the basis of health status. The Act also includes a series of reductions in spending under Medicare.¹

In this memorandum, we present estimates of the impact of the Act on sources of insurance coverage and provider incomes. We present our results in the following sections:

- Insurance exchanges and the public plan;
- Medicare payment reforms;
- Coverage effects;
- Detailed physician impacts analysis; and
- Detailed hospital impacts analysis.

¹ 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.

A. Insurance Exchanges and the Public Plan

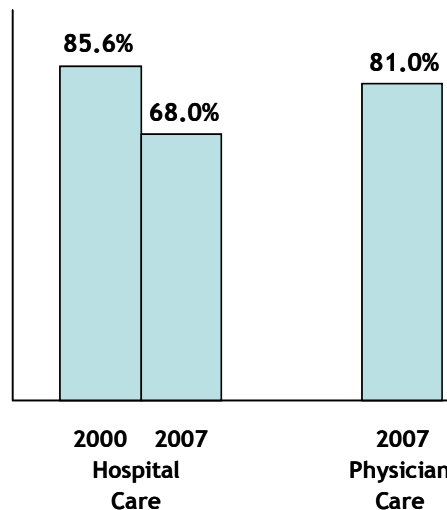
The Act would establish a nationwide network of health insurance exchanges. The exchange would provide consumers with a selection of health insurance plans competing on the basis of price and quality. It is designed to provide consumers with a transparent marketplace for coverage that features consumer protections and facilitates enrollment. Eligibility to participate in the exchange would be phased in over three years as follows:

- Year 1: Individuals and employers with 10 or fewer workers;
- Year 2: Individuals and employers with 20 or fewer workers; and
- Year 3: Individuals and employers of any size allowed by a newly established “Health Choices Commissioner.”

One of the coverage options offered through the exchange would be a new public plan, modeled on Medicare. Participants would pay actuarially determined premiums set at levels required to pay the full cost of coverage under the public plan. The public plan would be available to anyone eligible to enroll in the exchange. Thus, by the third year of the program individuals and all employers would be eligible to enroll in the public plan.

The public plan would pay health care providers using the Medicare payment methodology. As shown in *Figure 1*, Medicare payments to hospitals are equal to only about 68 percent for what private insurers pay for the same services. In fact, hospital payments as a percentage of private payer rates have declined steadily since 2000. Physician payments are equal to only about 81 percent of what is paid by private insurers for comparable services.

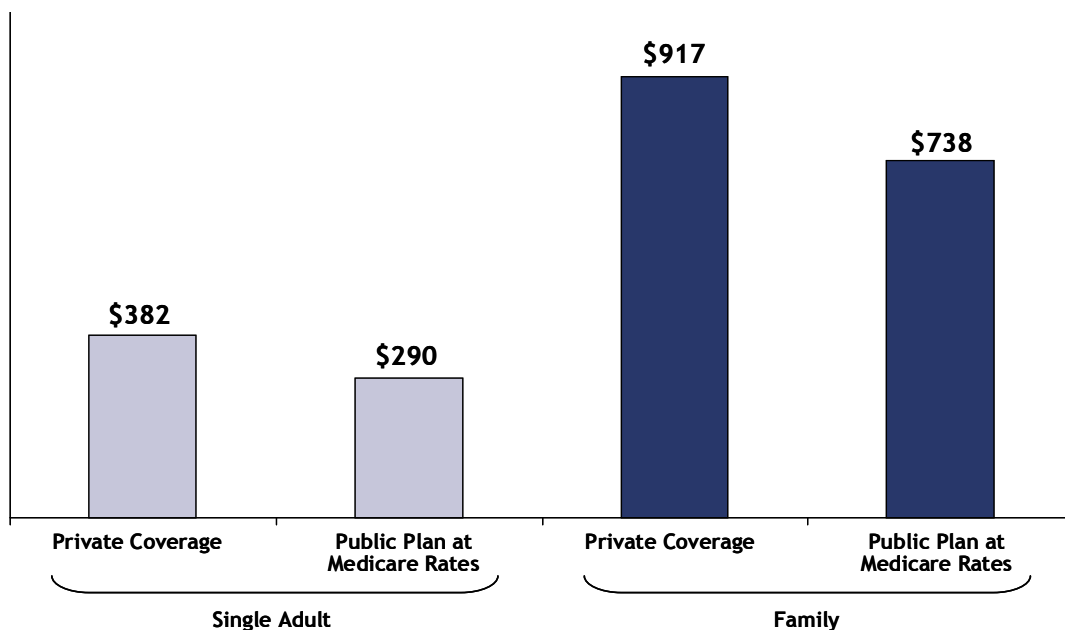
Figure 1
Medicare Provider Payments as a Percent of Private Payer Rates



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.

Because Medicare pays providers substantially less than private insurers, premiums for the public plan would be substantially less than comparable coverage in a private plan. We estimate that the average premium under the “enhanced” benefits package would be \$917 per month for private coverage compared to \$738 per month under the public plan in 2010 (*Figure 2*). These represent savings of between 20 percent and 25 percent.

Figure 2
Cost of the “Enhanced” Benefits Package under Private Coverage and the Public Plan under the Act ^{a/}



a/ Premiums are estimated for people with private coverage under current law. Family coverage includes families, couples and single parent households.
 Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

These estimates are based upon the demographic and health characteristics of the population eligible to enroll in the exchange. In addition to payment level differences, they reflect differences in administrative costs and the levels of benefit management under plan alternatives. They are adjusted to reflect an increase in cost shifting resulting from the use of Medicare payment rates, which are typically less than the cost of services provided by hospitals to the existing Medicare population. The derivation of these premiums is presented in *Appendix A*.

B. Medicare Payment Reforms

The Act includes over 80 sections that alter Medicare provider payment policies for virtually all types of providers of health services including physicians, hospitals, home health agencies, skilled nursing facilities, rehabilitation hospitals and other health care practitioners. Several of these changes are designed to encourage improved quality and efficiency such as bundled payments and quality related payments such as pay-for-performance. Total reductions in payments to providers under the bill would be \$361.9 billion (*Figure 3*).

The Act also permanently replaces the “sustainable growth rate” (SGR) formula for Medicare payments to physicians and other health practitioners. This averts the 21 percent reduction to payment levels that is scheduled to occur under current law. However, Congress is expected to act to prevent these payment reductions as they have done in each of the past several years, regardless of health reform. This is also assumed in President Obama’s proposed budget. Consequently, we present our physician-impacts estimates with and without the effects of replacing the SGR.

Figure 3
CBO Estimates of the Effects of Medicare Reforms under the Act on Provider Incomes: 2010-2019
(billions)

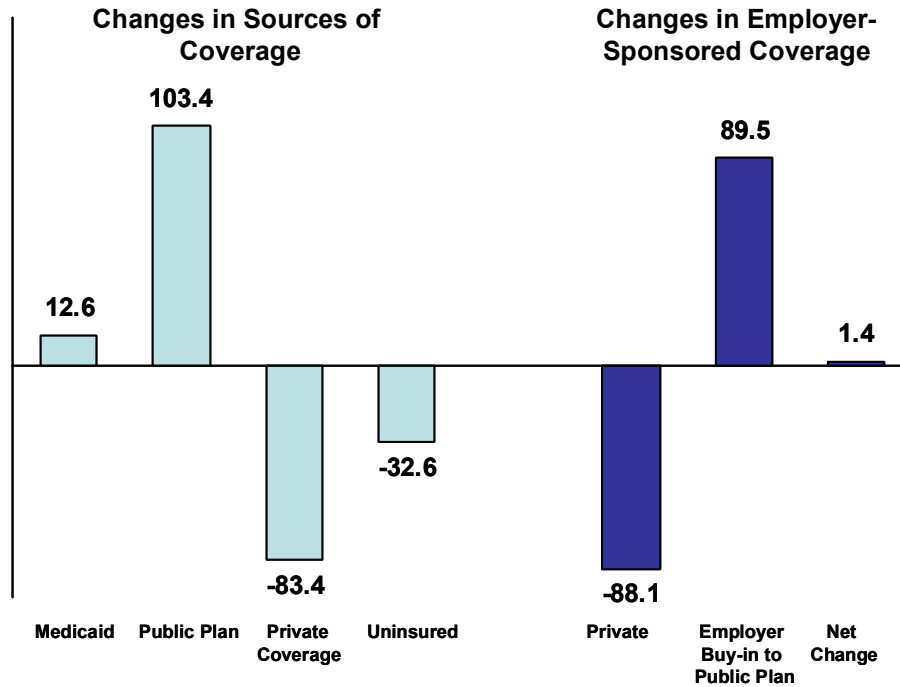
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Changes in Expected Payments to Providers											
Hospital	-2.5	-3.6	-6.9	-10.4	-23.6	-24.5	-26.7	-35.5	-41.7	-45.1	-220.6
Physician	1.5	2.9	3.8	4.1	-0.8	1.3	2.8	3.0	3.3	3.8	25.6
Other Professional	0.2	0.5	0.6	0.7	0.0	0.4	0.6	0.3	-0.6	-4.1	-1.5
Dental	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Home Health	0.0	0.2	0.1	-0.1	-1.0	-0.7	-0.5	-0.6	-0.7	-0.8	-4.3
Prescription Drugs	-0.1	-5.6	-7.3	-6.8	-8.5	-6.6	-3.3	-2.5	-2.7	-1.7	-45.3
Other Non-Durables	0.0	-0.4	-0.1	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.7
Durables	0.0	0.1	0.1	0.1	-0.2	0.0	0.1	0.1	0.1	0.1	0.5
Nursing Home	-0.9	-1.3	-1.4	-1.8	-3.2	-3.2	-3.5	-4.2	-4.7	-5.5	-29.7
All Services	-1.8	-7.3	-11.0	-14.1	-37.4	-33.4	-30.6	-39.5	-47.3	-53.4	-275.8
Other Effects											
Sustainable Growth Rate	7.4	13.1	15.3	17.6	20.3	23.5	27.5	31.3	34.4	38	228.4
Medicare Advantage	0	-4.6	-10.3	-14.9	-18.3	-19.7	-20.9	-22.5	-24.6	-26.7	-162.5
Interactions	3.1	4.8	1.9	1.1	-1.2	-1.3	-1.6	-3.7	-4.9	-6.2	-8.0
Total	8.7	6.0	-4.1	-10.3	-36.6	-30.9	-25.6	-34.4	-42.4	-48.3	-219.7

Source: Congressional Budget Office, Letter to Charles Rangel, Chairman Committee on Ways and Means, U.S. House of Representatives, July 17, 2009, Estimate of the Effects on Direct Spending and Revenues of Divisions B and C and Section 164 of H.R. 3200, The American’s Affordable Health Choices Act, as introduced on July 14, 2009.

C. Coverage Effects

We estimate that there will be about 49.1 million uninsured people in 2011. Once the program is implemented, we estimate that the number of uninsured people would be reduced by 32.6 million people (*Figure 4*). Enrollment in the expanded Medicaid program would increase by 12.6 million people. This includes about 15.5 million newly enrolled people, less about 2.9 million current enrollees who would become covered by employers who start to offer coverage in response to the mandate.

Figure 4
Changes in Sources of Coverage under the American Affordable Health Choices Act Assuming Full Implementation in 2011 (millions)



a/ This scenario assumes that the exchange is open to all individuals and employees in 2011.
 Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

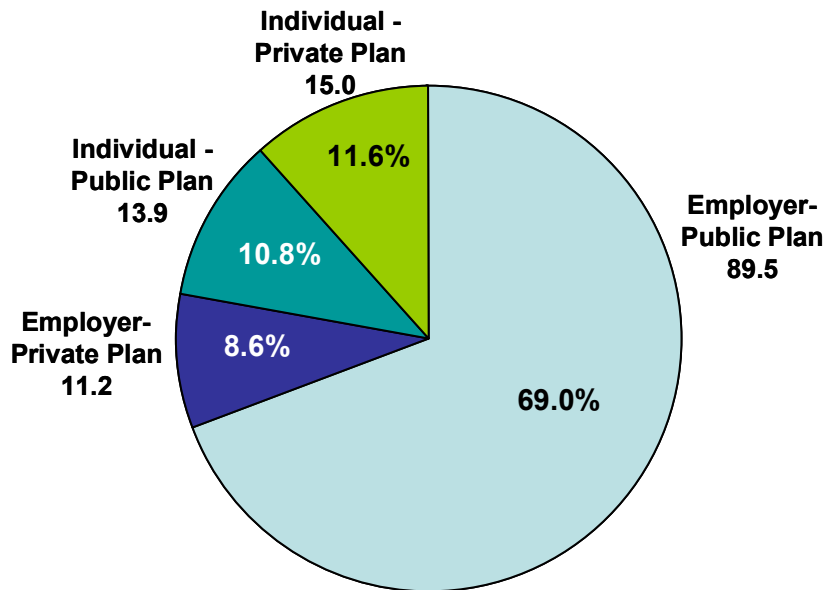
Once fully implemented in year 3 of the program (2015), individuals and all employers would be permitted to participate in the exchange and the public plan. If fully implemented in 2011, we estimate that about 103.9 million people would become covered under the newly established public plan. Coverage under private insurance would decline by 83.4 million people. This is a 48.4 percent reduction in the number of people with private insurance (currently 172.5 million people).

Under current law, there will be about 158.1 million people who are covered under an employer plan as workers, dependents or early retirees in 2011. If the Act was fully implemented in that year, about 88.1 million workers would shift from private employer insurance to other options. However, about 89.5 million people would become covered under the public plan with an employer paying a share of the premium. This is a net increase in the number of people with coverage where the employer is paying a portion of the premium, reflecting the effect of the employer mandate under the Act.

Overall, 129.6 million people would obtain coverage through the exchange (*Figure 5*). These include about 100.9 million people obtaining coverage with the aid of an employer premium contribution; which includes 89.5 million people covered under the public plan and 11.4 million taking coverage under a private health plan offered in the exchange. About 28.7 million people

would obtain coverage as individuals in the exchange, of whom about half would be enrolled in the public plan. A detailed analysis of changes in sources of coverage is presented in *Appendix B*.

Figure 5
Number of People Covered under the Exchange Assuming Full Implementation in 2011 (millions)



Number Enrolled in Exchange = 129.6

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

In *Figures 6 and 7*, we present the distribution of enrollees in the public plan across demographic groups. Enrollees are presented by family income, age of the family head and type of enrollment (employer, individual, recipient of subsidies). In addition, we present workers and dependents by firm size and industry. Estimates are provided separately for people with private employer coverage under current law who shift to the public plan.

Figure 6
Number Covered under the Public Plan under the House Bill in 2011
Nationally by Income, Age and Subsidy Status (thousands)

	All In Public Plan	Privately Insured Who Move to Public Plan
Family Income		
Less than \$10,000	1,319	626
\$10,000-\$19,999	2,783	1,044
\$20,000-\$29,999	4,808	2,221
\$30,000-\$39,999	7,503	4,758
\$40,000-\$49,999	8,059	5,647
\$50,000-\$74,999	18,919	15,096
\$75,000-\$99,999	18,240	16,403
\$100,000-\$149,999	21,905	20,173
\$150,000 or more	19,950	18,399
Age		
< 19	28,831	24,078
19-24	7,482	4,883
25-34	17,926	13,713
35-44	17,466	14,438
45-54	18,131	15,623
55-64	12,717	10,741
65 +	932	890
Receive Subsidy		
No	91,755	80,795
Yes	11,728	3,571
TOTAL	103,484	84,366

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

Figure 7
Number of People Enrolled in Public Plan by Industry and Firm Size
 (thousands)

	All In Public Plan	Privately Insured Who Move to Public Plan
Workers and Dependents		
Firm Size		
Under 10	14,624	9,315
10-24	9,650	6,989
25-99	12,165	9,724
100-499	10,442	8,664
500-999	3,643	3,263
1000-4999	6,136	4,683
5000+	28,693	27,075
Government	15,253	14,200
Industry		
Construction	7,808	5,283
Manufacturing	15,899	14,232
Transportation	5,370	4,544
Wholesale	3,487	3,147
Retail	9,324	7,537
Services	32,128	25,395
Finance	8,098	7,254
Government	15,253	14,200
Other	3,240	2,321

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

D. Detailed Physician Impacts Analysis

We estimated the changes in net-income to physicians and other health practitioners resulting under the Act. These estimates reflect reductions in uncompensated care as the number of people without health insurance declines. These reductions in uncompensated care represent a net increase in income to providers. We also include increases in revenues for new health services utilization among newly insured people at the provider payment levels used under these programs. We adjusted revenues from private insurers to simulate the effect of shifts in enrollment to the public plan at various provider payment levels for the four scenarios. Finally, we include the effect of an extensive list of reforms in Medicare payments included in the Act, which would generally reduce provider reimbursement (*Figure 8*).²

² As discussed above, we assume that the effects of replacing the SGR as proposed in the President's Budget are included in the current policy baseline.

In addition, we estimated increases in practice expense associated with providing services to the newly insured. We assumed that the marginal cost of providing these services is equal to 80 percent of average costs.³ The resulting data show the net change in physician revenues and net income under each of the public plan scenarios considered in this study (*Figure 8*).

Figure 8
Impact of Public Plan on Physician and Other Practitioner Revenues, Expenses and Net Income under the Act by Public Plan Eligibility Group in 2011

	Groups Eligible for the Public Plan			
	No Public Plan	Year 1: Individuals and Firms with Fewer than 10 Workers	Year 2: Individuals and Firms with Fewer than 20 Workers	Year 3: Individuals and All Firms
Physician Revenue Effects Without SGR Replacement (billions)				
New Utilization	\$14.1	\$14.7	\$15.0	\$15.1
Reduced Uncompensated Care	\$1.3	\$1.4	\$1.5	\$1.6
Increased Payments for Primary Care Under Medicaid	\$8.4	\$8.4	\$8.4	\$8.4
Reduced Benefits Management Effect	\$0	\$1.4	\$2.4	\$8.2
Public Plan Payment Level Adjustment ^{a/}	-\$1.9	-\$5.5	-\$9.3	-\$31.7
Medicare Payment Adjustments ^{b/}	\$1.3	\$1.3	\$1.3	\$1.3
Net Change	\$23.2	\$21.7	\$19.3	\$2.9
Physician Costs for New Health Services Utilization (billions)				
Costs for Newly Insured	\$7.4	\$8.5	\$9.1	\$12.2
Changes in Physician Net Income Without SGR Replacement (billion)				
Change in Net Income	\$15.8	\$13.2	\$10.2	-\$9.3
Change in net income per physician in 2011	\$22,644	\$19,292	\$14,213	-\$13,117
With replacement of SGR				
Sustainable Growth Rate	\$18.1	\$18.1	\$18.1	\$18.1
Change in Net-Income	\$33.9	\$31.3	\$28.3	\$8.8
Change in net income per physician in 2011	\$48,584	\$45,745	\$39,433	\$12,411

a/ Reflects changes in payment levels for people moving to the public plan and currently insured people and includes changes resulting from privately insured people who shift to the expanded Medicaid program.

b/ As discussed above, we assume that the effects of replacing the SGR as proposed in the President's budget are included in the current policy baseline. Includes payment changes for year 3 of the program (2015) at 2011 health care price levels.

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

³ This is the assumption used by the Center for Medicare and Medicaid Services (CMS) in calculating outlier payments.

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We estimated the incomes of physicians under current law based upon data obtained from the American Medical Association (AMA). We estimate that average revenues per physician under current law will be \$766,500 in 2010. Of this, about 61 percent would be attributed to medical practice costs. Net income per patient care physician (excluding hospital employees) will be \$299,700 in that year.^{4,5,6}

Figure 8 presents our estimates of the effect the Act would have on income for physicians and other practitioners. Assuming the program is fully implemented in 2011 (i.e., assume that year 3 of the program occurs in 2011), we estimate that Physician net-income would fall by \$9.3 billion, which is a reduction of 7.6 percent. The loss of net-income under this scenario would average about \$13,177 per physician assuming the program is fully implemented in 2011. When the replacement of the SGR is included, the change in net-income under the Act would be an increase of \$8.8 billion.

We also present in *Figure 8* estimates of the changes in physician income under scenarios where there is no public plan and under scenarios where enrollment is limited to individuals and smaller employers.

E. Detailed Hospital Impacts Analysis

We estimated the impact of the Act on hospital net-income under the Act. We used data primarily from the Medicare Hospital Cost Reports for federal fiscal year 2006. These data provide information on total hospital net patient revenues, other income, total operating expenses and other expenses for each U.S. hospital. The Medicare Hospital Cost Report data also includes information on revenues and expenses related to Medicare patients, uncompensated care expenses and inpatient utilization for Medicare, Medicaid and all other payers. All hospital payments and revenues were controlled to match hospital totals from the National Health Expenditure data by payer category and inflated to 2011.^{7,8}

We used these data to estimate the change in hospital revenues resulting from the various health reform options. These reflect reductions in uncompensated care resulting from expanded health insurance coverage, which represents a net increase in revenues to hospitals. We then estimated increases in revenues for new health services utilization for the newly insured at the provider payment levels used under affected programs including Medicaid, private insurance and self-pay. Finally, we adjusted revenues from private insurers to simulate the effect of shifts in enrollment to the public plan at various provider payment levels (*Figure 9*).

⁴ "Physician Characteristics in the US: 2007 Edition," American Medical Association

⁵ "Physician Socioeconomic Statistics: 2000-2002 Edition," American Medical Association

⁶ "Cost Survey for Multispecialty Practices: 2006 Report," Medical Group Management Association

⁷ Centers for Medicare & Medicaid Services, June 11, 2009 at <http://www.cms.hhs.gov/nationalhealthexpenddata/>

⁸ American Hospital Association, "Trendwatch Chartbook 2009"

In addition, we estimated increases in operating expense associated with providing services to the newly insured. We assumed that the marginal cost of providing these services is equal to 80 percent of average costs. The resulting data show the change in hospital net income under five public plan design scenarios.

We estimate that total hospital net income will be about \$52.9 billion in 2011 under current law. This is an average hospital margin of 6.0 percent. If the public plan is open to individuals and all employers using Medicare payment levels, hospital net income would fall by \$61.9 billion, which roughly eliminates total hospital margin for the year (*Figure 9*).

Figure 9
Impact of Public Plan on Hospital Revenues and Expenses under the Act by Public Plan Eligibility Group in 2011

	Groups Eligible for the Public Plan			
	No Public Plan	Year 1: Individuals and Firms with Fewer than 10 Workers	Year 2: Individuals and Firms with Fewer than 20 Workers	Year 3: Individuals and All Firms
Hospital Revenue Effects (billions)				
New Utilization	\$17.0	\$17.6	\$18.1	\$18.4
Reduced Uncompensated Care	\$14.5	\$15.0	\$15.4	\$15.6
Reduced Benefits Management Effect	\$0.0	\$1.3	\$1.8	\$7.3
Payment Level Adjustment ^{a/}	-\$1.2	-\$11.5	-\$15.5	-\$63.7
Medicare Payment Reductions ^{b/}	-\$18.9	-\$18.9	-\$18.9	-\$18.9
Net Change	\$11.4	\$3.5	\$0.9	-\$41.3
Hospital Costs for New Health Services Utilization (billions)				
Costs for Newly Insured	\$13.6	\$15.1	\$15.9	\$20.6
Changes in Hospital Net Income (billion)				
Change in Net income ^{c/}	-\$2.2	-\$11.6	-\$15.0	-\$61.9

a/ Reflects changes in payment levels for people moving to the public plan and currently insured people and includes changes privately insured people who shift to the expanded Medicaid program.

b/ Includes payment reductions for year 3 of the program (2015) at 2011 health care price levels.

c/ Medicaid Disproportionate Share Hospital (DSH) payments will be reduced starting in 2017 by 1.5 billion in 2017, 2.5 billion in 2018 and 6.0 billion in 2019.

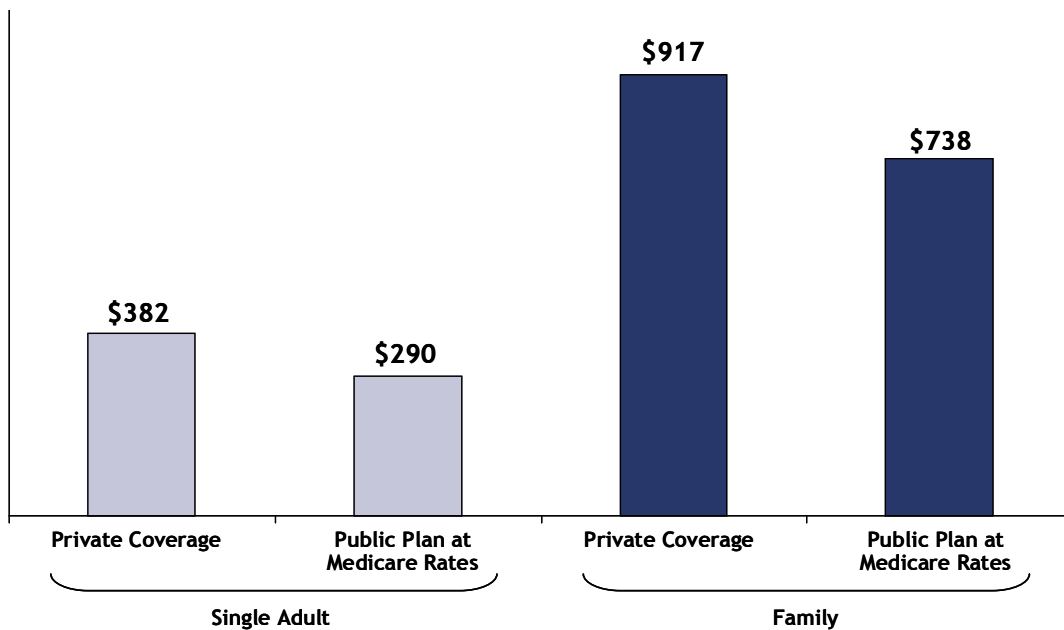
Source: The Lewin Group analysis using the Health Benefits Simulation Model (HBSM).

**Appendix A
 Derivation of Public Plan Premiums**

We estimated the premium for private health plans and the public plan under The American Affordable Health Choices Act of 2009. These estimates are based upon the demographic and health characteristics of the population eligible to enroll in the exchange. They also reflect differences in administrative costs and the levels of benefit management under plan alternatives. However, the most important driver of premiums in the public plan will be provider payment levels.

For illustrative purposes, we provide in this section a detailed description of how we estimated premiums for insurance in the exchange assuming that all firms are eligible to participate in the exchange. To assure comparability, both premiums were estimated using an identical benefits package for a uniform population with identical characteristics. These include all people now covered under private insurance. For illustrative purposes, we present our estimates of premiums for the “Enhanced” benefits package under the Act. The average premium per privately insured family in 2010 would be \$917 per month for private coverage compared to \$738 per month under the public plan (*Figure A-1*).

**Figure A-1
 Monthly Cost of the “Enhanced” Benefits Package under Private Coverage and the Public Plan under the Act ^{a/}**



a/ Premiums are estimated for people with private coverage under current law. Family coverage includes families, couples and single parent households.

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

Thus, premiums for the public plan would be 20 percent to 25 percent less than for comparable private coverage. For some individuals and small employers, savings would be 30 percent or more. These savings derive primarily from the fact that provider payment levels under Medicare are substantially lower than for private payers. Also, the public plan would not include an allowance for profit or broker commissions, further reducing the public plan premium.

The premiums for each of the three public plan scenarios were estimated for the populations eligible to participate under each option (e.g., small firms, large firms etc.) For illustrative purposes, we present in a detailed description of the approach used to estimate premiums per policy holder (i.e., average across individual and family policies) using payment levels (*Figure A-2*). In addition to payment levels and administrative costs, these estimates reflect the impact of cost-shifting, risk selection and differences in utilization review practices.

Figure A-2
Monthly Premiums per Policy Holder under Private Insurance and the Public Plan for the “Enhanced” Benefits Package under the Act in 2010^{a/}

	Premiums in Public Plan per Policy Holder			Private Plan Premiums per Policy Holder		
	Benefits Costs	Administ ration	Total	Benefits Costs	Administ ration	Total
Public Plan Available to individuals and all Employers						
Current Law Premiums: All Firms	\$565.36	\$77.45	\$642.81	\$565.36	\$77.45	\$642.81
Changes in Premiums						
Payment Level Adjustment ^{b/}	-\$123.52	\$0.00	-\$123.52	\$0.00	\$0.00	\$0.00
Administrative Savings	\$0.00	-\$37.89	-\$37.89	\$0.00	\$0.00	\$0.00
Selection Effects	\$32.99	\$0.00	\$32.99	-\$29.60	\$0.00	-\$29.60
Reduced Utilization Review	\$26.90	-\$2.96	\$23.94	\$0.00	\$0.00	\$0.00
Cost Shift	\$0.00	\$0.00	\$0.00	\$54.12	\$0.00	\$54.12
Total Premiums Under Public Plan for Individuals and all Employers						
Total	\$501.75	\$36.6	\$538.35	\$589.88	\$77.45	\$667.33

a/ Premiums for policy holders with private coverage under current law. Premiums are an average across family and individual policies.

b/ Assumes provider payment levels are set at Medicare payment levels, with physicians and other professionals receiving an additional 5 percent if they accept patients from both the public plan and Medicare.

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

We estimated these premiums in several steps described in the following sections:

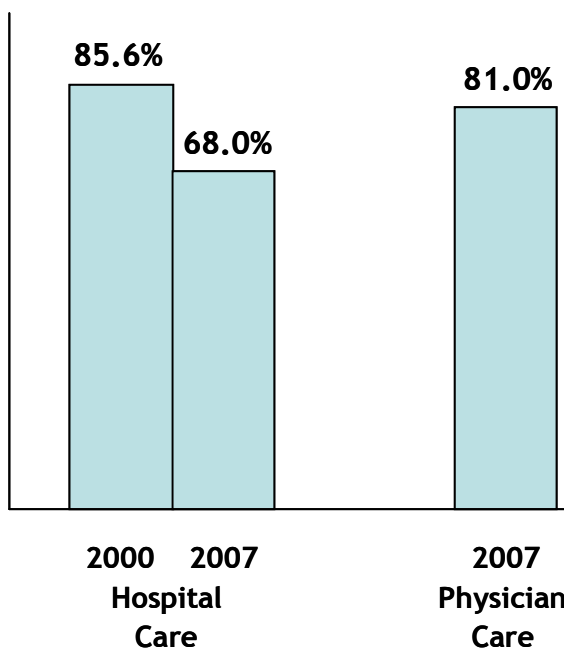
- Provider payment levels;
- Public plan administrative costs;
- Utilization review and costs;

- Cost-shifting under the public plan; and
- Enrollment and risk selection.

1. Provider Payment Levels

Provider payment levels for hospital services under Medicare are equal to only about 68.0 percent of what is paid by private health plans for the same services (*Figure A-3*). In fact, Medicare payments to hospitals are equal to only about 91 percent of the actual cost of the services provided.^{9,10} For physician services, Medicare pays only about 81.0 percent of what is paid by private health plans for the same services.¹¹

Figure A-3
Medicare Provider Payments as a Percent of Private Payer Rates



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.

For illustrative purposes, we assume that all physicians and other professionals would agree to see both public plan and Medicare patients. Based upon these figures, we estimate that average

⁹ American Hospital Association, “Trends Affecting Hospitals and Health Systems,” TrendWatch Chartbook, April 2008.
¹⁰ Lewin Group estimates that Medicare allowable costs were 7 percent to 8 percent less than hospital’s reported costs in 2007. Unlike the AHA data used here, this estimate does not include the Medicare non-allowable costs (e.g., advertizing, entertainment, penalties, gifts, donations, employee education, etc.).
¹¹ State Health Facts, The Kaiser Family Foundations (KFF), 2003 report

payments for hospitals and other providers under a public plan using Medicare payment rates would be roughly 25 percent less than under private health plans.

As shown in *Figure A-3*, the disparity between public and private payments for hospitals has grown in recent years. Medicare payment rates for hospitals have fallen from 85.6 percent of private sector payments in 2000 to 68.0 percent in 2007. This disparity could continue to grow into the next decade, suggesting that our use of payment differentials in 2007 may understate our estimate of the impact on provider incomes for 2010.

2. Administrative Costs

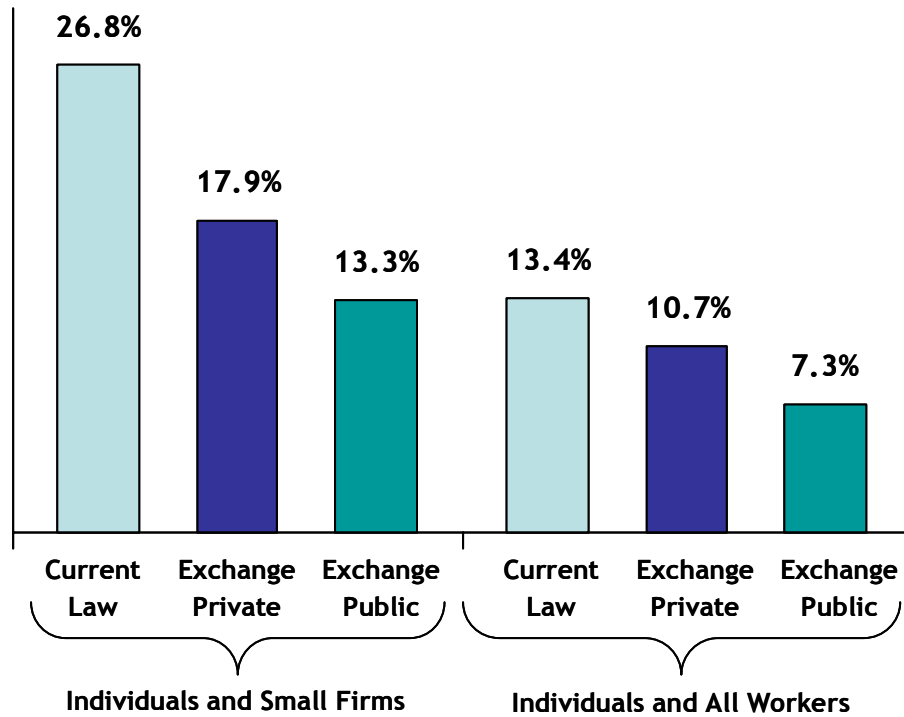
Administrative costs are also expected to be lower in the exchange than in the private market. We estimate that administrative costs for individuals and small firms under current law equal 26.8 percent of benefits costs (i.e., claims costs). We estimate that administrative costs in the exchange for individuals and small firms would be equal to 17.9 percent of benefits costs (*Figure A-4*). This is based upon actuarial estimates of how administrative costs are reduced through economies of scale in insurance pools.¹²

We assume that administrative costs in the public plan would be the same as for other plans in the exchange, with the exception that the public plan would not include an allowance for insurer profit and insurance agent and broker commissions and fees. Administrative costs for individuals and small employers in the public plan would be about 13.3 percent of benefits costs. If extended to employers of all sizes, administrative costs in the public plan would average about 7.3 percent of claims costs.

Thus, our administrative cost estimates are based upon costs for private health plans rather than Medicare, which we adjusted for the elimination of profits and agent/broker commissions. We chose this approach because the Medicare administrative cost figures for the existing Medicare program do not reflect the cost of administering changes in coverage over time as people change jobs.

¹² Hay/Huggins data as appeared in: “Cost and Effects of Extending Health Insurance Coverage,” The Congressional Research Service, 1989.

Figure A-4
Administrative Costs as a Percent of Claims Cost



Source: The Lewin Group estimates.

3. Utilization Review and Costs

Premiums in the public plan would also differ from private plans due to differences in the level of utilization management. Private insurers typically employ utilization management programs designed to avoid unnecessary utilization of health services. These include pre-certification for high-cost procedures, disease management, concurrent utilization review and discharge planning. These approaches are also emphasized in integrated delivery systems such as HMOs to keep patients healthy and to improve efficiency.

While the Medicare program does have some pre-certification requirements, they are less extensive than those used in most private plans. Therefore, we adjusted the public plan premiums to reflect that these utilization review processes are less widely used in Medicare.

At the beginning of Title XVIII of the Social Security Act, it reads:

Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise

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any supervision or control over the administration or operation of any such institution, agency, or person.

The language essentially precludes the Centers for Medicare & Medicaid Services (CMS) from administering prior authorization procedures in the Medicare FFS program. In fact, the Government Accountability Office (GAO) recently recommended that CMS consider a front-end payment safeguard mechanism such as prior authorization in response to the rising utilization of advanced imaging procedures.¹³ We have even seen prior authorization for imaging services as a recommendation in President Obama's budget projections and scored by the Congressional Budget Office, but at this point CMS is basically limited to setting coverage limits and retrospective medical necessity payment reviews and has acknowledged that prior authorization may not be applicable in the Medicare FFS program.¹⁴ For this reason, the Medicare program does not utilize as many payment safeguard mechanisms as can be utilized in the private insurance sector.

Studies of private utilization management programs have shown that these programs reduce health spending. A study by Feldstein et al. showed that these utilization review methodologies reduced plan costs by 8.4 percent.¹⁵ They found that these programs saved plans eight dollars for every dollar spent by the insurer to administer them. A study by Wickizer showed savings of six percent.¹⁶ Another more recent study showed savings of about four percent in PPOs and eight percent in HMOs.¹⁷ These estimates do not include the provider's cost of complying with utilization review.

In this study, we assumed that Medicare engages in about one-third of the utilization review used in private health plans. This resulted in an average increase in costs once enrolled in the public plan of 5.4 percent. We assumed that administrative costs in the public plan are reduced by 0.5 percent of benefits costs to reflect administrative savings from less extensive utilization review programs.

4. Cost-Shifting under Public Plan

The coverage expansions and the public plan would affect provider payments for private coverage through the "cost-shift." In today's system, hospitals and physicians provide a

¹³ Government Accounting Office. June 2008. *Medicare Part B Imaging Services: Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices*. GAO-08-452 <Available as of June 22, 2009 at <http://www.gao.gov/new.items/d08452.pdf>>.

¹⁴ Congressional Budget Office. December 2008. *Budget Options Volume 1: Health Care*; Government Accounting Office. June 2008. *Medicare Part B Imaging Services: Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices*. GAO-08-452 <Available as of June 22, 2009 at <http://www.gao.gov/new.items/d08452.pdf>>.

¹⁵ Feldstein, P., Wickizer, T. and Wheeler, J., "The Effects of Utilization Review of Health Care Use and Expenditures," *NEJM*, 1988; 318:1319-4, Volume 3

¹⁶ Wickizer, Thomas, "The Effects of Utilization Review on Hospital Use and Expenditures: A Covariance Analysis," *Health Services Research*, May 16, 1991.

¹⁷ Stapleton, D., "New Evidence on Savings from Network Models of Managed Care," (a report to the Healthcare Leadership Council), The Lewin Group, Washington, DC, May 1994

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substantial amount of free care to uninsured people called “uncompensated care.” Also, payments for Medicare and Medicaid are usually less than the cost of the services provided resulting in payment shortfalls. Hospitals and physicians cover the cost of uncompensated care and payment shortfalls under public programs by increasing charges for private health plans in a process known as cost-shifting.

In this analysis, we assumed that a portion of the reductions in uncompensated care resulting from an expansion in coverage would be passed back to privately insured people as a reduction in the cost-shift. This would take the form of a reduction in the rate of growth in provider charges. However, a public plan that pays providers at Medicare levels would increase shortfalls in reimbursement, resulting in increased cost-shifting to private payers. The net effect on provider incomes will depend upon the amount of the payment shortfall relative to the savings in uncompensated care.

The available research shows that not all of uncompensated care and government payment shortfalls are passed on to private payers as higher charges. 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.¹⁸ However, two other studies showed considerably less evidence of hospital cost-shifting, although they did not rule out a partial cost-shift.¹⁹ 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.²⁰

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.²¹ Based upon this research, we assume that 40.0 percent of increases in uncompensated care and payment shortfalls are passed on to private payers in the form of increased charges.

We estimate that premiums for privately insured people would increase by about \$460 per privately insured person under a public plan available to all individuals and employers using Medicare payment rates. This reflects the shortfalls in payments under the new public plan which is partially offset by the reduction in uncompensated care resulting from expanded coverage and increases in Medicaid reimbursement for primary care services under Medicaid.

¹⁸ 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)

¹⁹ 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)

²⁰ Rice, Thomas, et al., “Physician Response to Medicare Payment Reductions: Impacts on public and Private Sectors,” Robert Wood Johnson Grant No. 20038, September 1994.

²¹ 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

5. Enrollment and Risk-Selection

In this step, we use HBSM, a micro-simulation model of the US health care system, to identify privately insured individuals and employers who would be eligible to purchase coverage at a lower cost through the public plan. We then simulate their decision to shift to the public plan based upon studies of how people respond to changes in the relative price of insurance within employer groups offering a choice of health plans.²² We simulate these shifts in a two step process that allocates affected people into one of the following three groups:

- People who remain with their current private health plan rather than shifting to the public plan;
- People who drop private coverage to enroll in the public plan due to the lower premiums; and
- People who leave the public plan to enroll in a lower cost HMOs.

In the first step, we model the shift of privately insured individuals to the lower cost public plan. We do this using “plan change price elasticity” estimates developed by Strombom et al., showing that on average, a 1.0 percent decrease in the price of an alternative source of coverage is associated with a 2.47 percent migration of enrollees to the lower cost health plan.

The study shows that younger and healthier people are more likely to change plans in response to a change in premiums. This is consistent with the idea that older and sicker people are more likely to resist changing plans if it means their physician is not in the plan’s provider network. These estimates are consistent with other studies showing that people leaving fee-for-service (FFS) health plans for HMOs and other managed care plans tend to have lower costs than those who remain with FFS plans.²³

In the second step we model risk selection against the public plan. Some managed care plans would develop products that tend to attract younger and healthier people through benefit designs or marketing practice. This would tend to leave the public plan with higher cost individuals. We simulate this by assuming that private HMOs are able to offer a product that is four percent less costly than the premium for the public plan. This assumption is based upon research showing that utilization of health services in HMOs is about four percent less than in PPO and other FFS plans.

Using this approach, we estimate that the public plan would experience adverse selection of about 7.1 percent. This would be met with favorable selection of about 5.0 percent in the remaining private insurance markets (including private plans in the exchange). This is a

²² Strombom, B., Buchmueller, T., Feldstein, P. “Switching Costs, Price Sensitivity and Health Plan Choice,” *Journal of Health Economics*, 21 (2002), 89-116.

²³ David M. Cutler and Richard J. Zeckhauser, “Adverse Selection in Health Insurance,” National Bureau of Economic Research, working paper 6107, July 1997; and Paolo Belli, “How Adverse Selection Affects the Health Insurance Market,” Harvard School of Public Health.

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differential of about 12.7 percent between the two groups, over and above what is corrected for with age rating. In this scenario, we have assumed the use of age-rating with a 2 to 1 ratio between the highest and lowest cost age groups, with no premium adjustment for health status.

The Strombom results were within the range of the available estimates of the price response due to changes in the relative prices of insurance. Several estimates of price elasticity of demand from previous research have ranged from -0.8 to -6.2 depending on the types of plans analyzed, as well as variations in the models used to estimate the price elasticity.²⁴ We selected the work of Strombom et al. because it allows us to show how the price response varies with age and health status.

²⁴ Royalty AB and Solomon N. 1999. "Health Plan Choice: Price Elasticities in a Managed Competition Setting," *The Journal of Human Resources*, 34(1): 1-41; Buchmueller TC and Feldstein PJ. 1996. "The Effect of Price on Switching Among Health Plans," 16(1997): 231-247. Cutler DM, Reber S. 1996. "Paying for Health Insurance. The Tradeoff between Competition and Adverse Selection," *NBER Working Paper #5796*.