

The Impact of the House Health Reform Legislation on Coverage and Provider Incomes

Testimony before the Energy and Commerce Committee,
U.S. House of Representatives

John Sheils

Vice President

The Lewin Group

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About The Lewin Group

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Summary and Introduction

The House bill includes a public plan as part of a broad health reform proposal that would expand health insurance coverage. The program expands increases Medicaid eligibility to 133 percent of the federal poverty level (FPL) and provides individual subsidies for the purchase of insurance for people between 133 percent and 400 percent of the FPL. Tax credits are available to small employers who purchase coverage, while larger employers are also required to contribute to the cost of coverage for workers. Individuals who do not have coverage would be fined 2.0 percent of their income up to the national average premium amount.

The bill would permit individuals and employers to purchase health insurance from a newly created “public plan” modeled on Medicare. The public plan would compete for enrollment with private insurers in a newly formed network of “exchanges” that present a selection of competing health plans to consumers. The public plan would be required to follow the same rules concerning pre-existing conditions and premium rating practices that apply to private plans.

We estimate that the public plan under the House bill would have premiums that are 20 percent to 25 percent less than for comparable private coverage. The bill specifies that the program would pay providers at Medicare levels, which are 20 percent to 30 percent less than what private plans pay for the same services. The bill would pay physicians at Medicare levels plus 5 percent if the provider agrees to serve both Medicare and public plan participants. Also, the public plan does not require an allowance for profits and there would be no broker/agent commissions.

We estimate that the bill would cover about 24.0 million of the 48.9 million people that we estimate will be uninsured in 2010 (*Figure ES-1*). Medicaid enrollment would increase by 16.0 million people. If the plan is implemented without a public plan option, the number of people with private insurance coverage would increase by 8.0 million people.

The public plan under the House bill would result in a substantial decline in the number of people with private insurance coverage, even in the early years of the program. In the first year of the program, individuals and firms with fewer than 10 workers are eligible to enroll in the public plan. We estimate that enrollment in the public plan would be 29,300 people in that year, with a reduction in private coverage of 20,600 people. In the second year, the bill extends eligibility to firms with fewer than 20 workers as well. Thus, in the second year, private insurance coverage would decline by 30.8 million people.

Beginning in the third year, the newly established “Health Choices Commissioner” would be permitted to extend eligibility to include all employers. If the plan is opened to individuals and all employers, the number of people in the public plan would rise to 122.9 million people. Private coverage would decline by about 113.5 million people.¹

¹ In an earlier analysis, we estimated that a public plan open to individuals and all employers using Medicare payment levels would reduce the number of people with private coverage. The reduction in coverage is smaller under the House bill because it pays physicians and other professionals Medicare payment levels plus 5 percent.

Figure ES-1
Changes in Hospital and Physician Net-Income under Alternative Public Plan Scenarios ^{a/}

	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
Coverage Effects (millions)				
Public Plan Enrollment	n/a	29.3	39.8	122.9
Change in Medicaid	16.0	16.0	16.0	15.8
Change in Private Coverage	8.0	-20.6	-30.8	-113.5
Change in Uninsured	-24.0	-24.7	-25.0	-25.2
Physician Impacts				
Change in Net-income (billions)	\$14.2	\$10.9	\$7.3	-\$11.5
Percentage Change in Net-income	6.6%	5.0%	3.3%	-5.4%
Change in Net-income Per Physician in 2010	\$19,795	\$15,237	\$10,141	-\$16,207
Hospital Impacts				
Change in Net-income (billions)	\$22.0	\$17.5	\$12.2	-\$11.5
Percent Change in Net-income	44%	35%	24%	-63%
Total Hospital Margin (Currently 6.0 Percent)	8.6%	8.1%	7.4%	2.2%

a/ All scenarios assume an expansion in health insurance coverage modeled on the description of the draft House bill as of June 19, 2009.
 Source: The Lewin Group estimates.

In the first year of the program, physician income would increase by \$10.9 billion. This reflects the reduction in uncompensated care for uninsured people as well as increased health services utilization for newly insured people. It also reflects the House bill provisions that would increase Medicaid reimbursement for primary care services to Medicare payment levels. Thus, the reductions in payment for people who shift to the public plan are outweighed by increases in reimbursement for Medicaid, reductions in uncompensated care and revenues from increased service use for newly insured people. Average net-income per physician would increase by \$15,237 in 2010 under this scenario.

Physicians would see an \$11.5 billion reduction in net-income if the public plan is opened to individuals and firms of all sizes. Here, the reductions in payments for people shifting to the public plan would be greater than the increases in net income due to increased Medicaid payment levels and new service utilization for newly insured people. The loss of net-income would average \$16,200 per physician.

Hospital net income would increase by \$17.5 billion in the first year of the program. This reflects reductions in uncompensated care and increased service utilization for newly insured people. However, if the public plan is opened to individuals and all employers, hospital net-income

would fall by \$11.5 billion. This reflects reductions in reimbursement for services provided to those who shift from the private coverage to the public plan.

In this study, we present estimates of the effect of the House bill on coverage and provider revenues under several variations on the design of the public plan. Our analysis is presented in the following sections:

- Health reform and the public plan;
- Premiums in the public plan;
- Coverage effects; and
- Provider impacts.

A. Health Reform and the Public Plan

The House bill includes a public plan as part of a broad health reform proposal to expand health insurance coverage. The program expands Medicaid eligibility to 133 percent of the federal poverty level (FPL) and provides individual subsidies for the purchase of insurance for people between 133 percent and 400 percent of the FPL. Tax credits are available to small employers who purchase coverage, while larger employers are also required to contribute to the cost of coverage for workers. The key features of his campaign proposal include:²

- Once fully implemented, all individuals are required to have coverage except in hardship cases, which we define to be people who are unable to obtain coverage for less than 10 percent of their income. Uninsured pay a penalty equal to 2.0 percent of income up to the national average premium amount;
- Medicaid eligibility is expanded to include all individuals living below 133 percent of the Federal Poverty Level (FPL), including able-bodied adults without custodial responsibilities for children;
- Sliding scale affordability tax credits are provided to people purchasing private insurance who live between 133 percent and 400 percent of the FPL;
- Medical underwriting and health status rating is eliminated in all insurance markets, and caps rate variation by age to a 2:1 rating band;
- Medium and large employers are required to offer insurance or pay a payroll tax (assumed to be 8.0 percent); and
- Tax credits are provided to small employers who purchase coverage.

The House bill would create an “insurance exchange” in each area of the country. The exchange would provide a selection of private health plans competing on the basis of price and quality, including HMOs and private fee-for-service plans such as Preferred Provider Organizations (PPOs). All individuals and self-employed people would be permitted to purchase coverage through the exchange. In addition, it would be open to employers 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. People would pay actuarially determined premiums set to be sufficient to fully fund coverage provided through the public program. The health insurance affordability tax credit for individuals created under the program could be used to help pay the premium. Because Medicare and other government programs pay providers substantially less than private insurers, premiums for the public plan could be substantially less than comparable coverage in a private plan.

² “McCain and Obama Health Care Policies: Cost and Coverage Compared,” The Lewin Group, October 8, 2008.

The House proposal would rely upon a newly formed Health Benefits Advisory Committee to specify a new essential benefits package. This new essential benefit package will serve as the basic benefit package for coverage in the exchange and over time will become the quality standard for employer plans. It includes preventive service at no cost sharing, mental health services, dental and vision for children, and caps the amount of money a person or family spends on covered services in a year. There would be four benefits levels:

- Essential/Basic: 70 percent actuarial value;
- Enhanced: 85 percent actuarial value;
- Premium: 95 percent actuarial value; and
- Premium Plus: Includes additional benefits (e.g., adult dental and vision).

In this analysis, we estimate the impact of the House bill on coverage and provider incomes under five alternative public plan designs including:

- Coverage expansion without a public plan;
- Year 1: A public plan open to individuals and firms with 10 or fewer workers;
- Year 2: A public plan open to individuals and firms with under 20 workers;
- Year 3: A public plan open to individuals and all employers.

The legislation specifies that payment levels in the public plan would be based upon Medicare payment levels. Physicians and other health professionals would receive an extra 5 percent if they agree to participate in both Medicare and the public plan. Also, Medicaid payment levels would be increased to Medicare levels for primary care providers under the Medicaid program.

We used The Lewin Group Health Benefits Simulation Model (HBSM) to simulate the effect of these variations assuming that each scenario is fully implemented in 2010.³

B. Premiums in the Public Plan

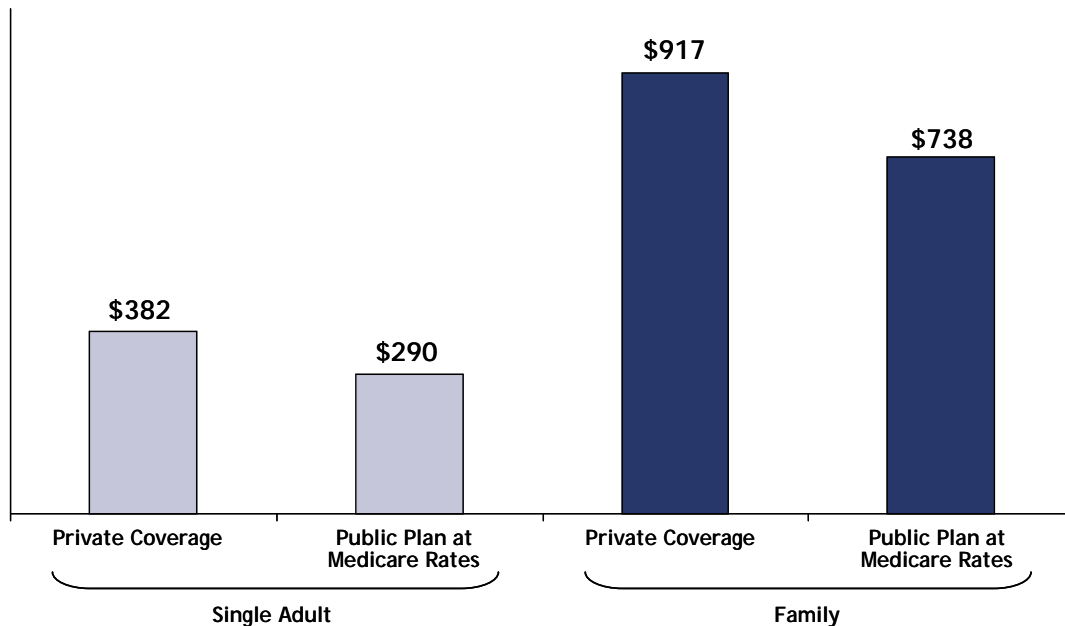
We estimated the premium for private health plans and the public plan under each of the four scenarios described above for the various benefits packages. These estimates are based upon the demographic and health characteristics of the population eligible to enroll in the exchange. They also reflect differences 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

³ "The Health Benefits Simulation Model (HBSM): Methodology and Assumptions," The Lewin Group, February 19, 2009.

premiums for the “Enhanced” benefits package under the House bill. 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 1*).

Figure 1
Cost of the “Enhanced” Benefits Package under Private Coverage and the Public Plan under the House Bill ^{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 2*). In addition to payment levels and administrative costs, these estimates reflect the impact cost-shifting, risk selection and differences in utilization review practices.

Figure 2
Monthly Premiums per Policy Holder under Private Insurance and the Public Plan for the
“Enhanced” Benefits Package under the House Bill 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:

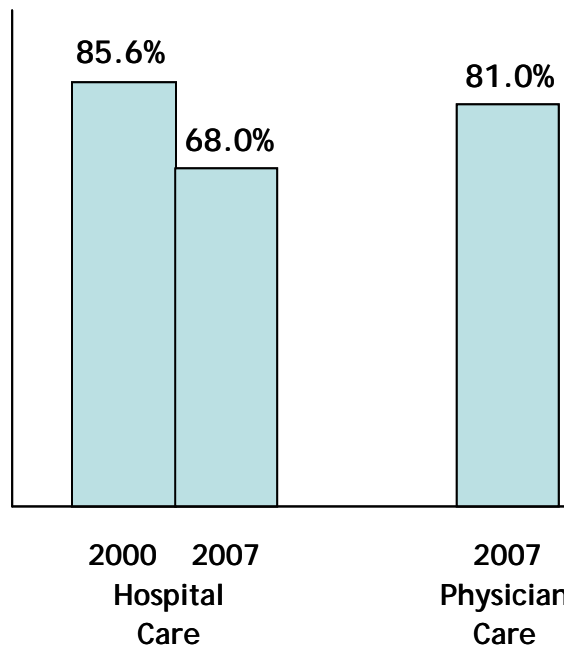
- Provider Payment levels;
- Public plan administrative costs;
- Elimination of utilization review;
- Cost-shifting; and
- Enrollment and risk selection.

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 3*). In fact, Medicare payments to hospitals are equal to only about 91 percent of the actual cost of the services provided.^{4,5} For physician services, Medicare pays only about 81.0 percent of what is paid by private health plans for the same services.⁶

⁴ American Hospital Association, “Trends Affecting Hospitals and Health Systems,” TrendWatch Chartbook, April 2008.

Figure 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 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 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

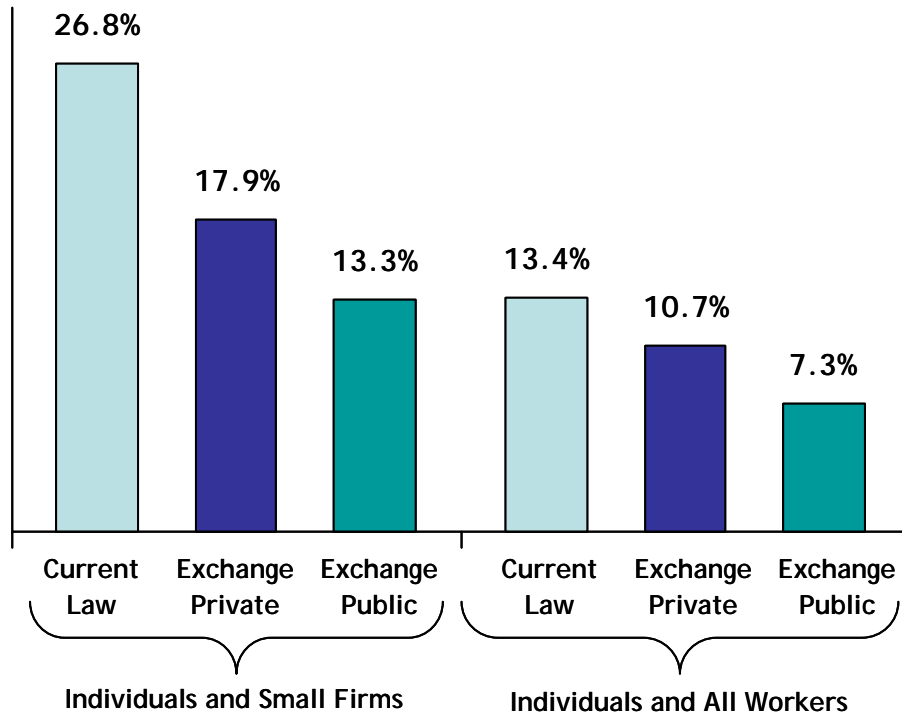
Administrative costs are also expected to be lower in the exchange than in the private market. We estimate that administrative costs for individuals and small firms under current law equal 26.8 percent of benefits costs (i.e., claims costs). We estimate that administrative costs in the exchange for individuals and small firms would be equal to 17.9 percent of benefits costs

⁵ 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., advertising, entertainment, penalties, gifts, donations, employee education, etc.).

⁶ State Health Facts, The Kaiser Family Foundations (KFF), 2003 report

(Figure 4). This is based upon actuarial estimates of how administrative costs are reduced through economies of scale in insurance pools.⁷

Figure 4
Administrative Costs as a Percent of Claims Cost



Source: The Lewin Group estimates. See administrative cost section below.

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.

⁷ Hay/Huggins data as appeared in: "Cost and Effects of Extending Health Insurance Coverage," The Congressional Research Service, 1989.

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 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 Accounting 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.⁸ 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.⁹ 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.¹⁰ 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

⁸ 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>>.

⁹ 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>>.

¹⁰ 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

percent.¹¹ Another more recent study showed savings of about four percent in PPOs and eight percent in HMOs.¹² 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 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.¹³ However, two other studies showed considerably less evidence of hospital cost-shifting, although they did not rule out a partial cost-shift.¹⁴ 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.¹⁵ Our own analysis of hospital data indicates that about 40 percent of the increase in hospital payment shortfalls (i.e.,

¹¹ Wickizer, Thomas, "The Effects of Utilization Review on Hospital Use and Expenditures: A Covariance Analysis," *Health Services Research*, May 16, 1991.

¹² 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

¹³ 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)

¹⁴ 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)

¹⁵ Rice, Thomas, et al., "Physician Response to Medicare Payment Reductions: Impacts on public and Private Sectors," Robert Wood Johnson Grant No. 20038, September 1994.

revenues minus costs) in public programs were passed-on to private-payers in the form of the cost-shift during the years studied.¹⁶ Based upon this research, we assume that 40.0 percent of changes in uncompensated care and payment shortfalls are passed on to private payers in the form of reduced 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.

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.¹⁷ 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.¹⁸

¹⁶ 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

¹⁷ Strombom, B., Buchmueller, T., Feldstein, P. “Switching Costs, Price Sensitivity and Health Plan Choice,” *Journal of Health Economics*, 21 (2002), 89-116.

¹⁸ 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.

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 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.

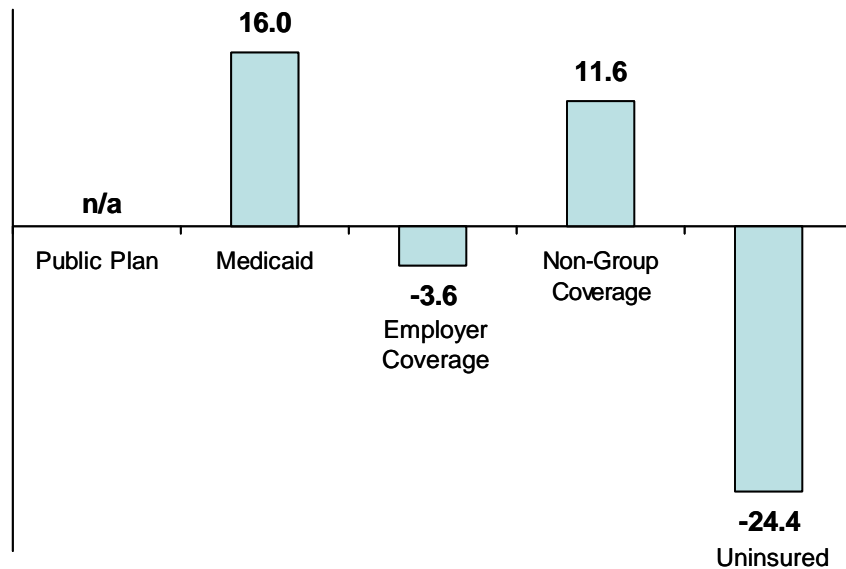
The Strombom results were within the range of the available estimates of the price response due to changes in the relative prices of insurance. Several estimates of price elasticity of demand from previous research have ranged from -0.8 to -6.175 depending on the types of plans analyzed, as well as variations in the models used to estimate the price elasticity.¹⁹ We selected the work of Strombom et al. because it allows us to show how the price response varies with age and health status.

B. Coverage Effects

We estimate that there will be about 48.9 million uninsured people in 2010. If the House bill were implemented without a public plan, about 24.0 million of these uninsured would become covered (*Figure 6*). Medicaid enrollment would increase by 16.0 million people. There would be a net reduction in the number of people with employer coverage of about 3.6 million people, despite the “pay-or-play” mandate. This is because many employer groups will find it less costly for workers to purchase non-group coverage with the assistance of the new subsidies, than it is to continue to provide insurance. The number of people with non-group coverage would increase by 11.6 million people, largely due to the affordability tax credits provided for the purchase of private coverage for those not eligible for employer insurance.

¹⁹ 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*.

Figure 6
Change in Sources of Coverage under The House Bill Assuming no Public Plan



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

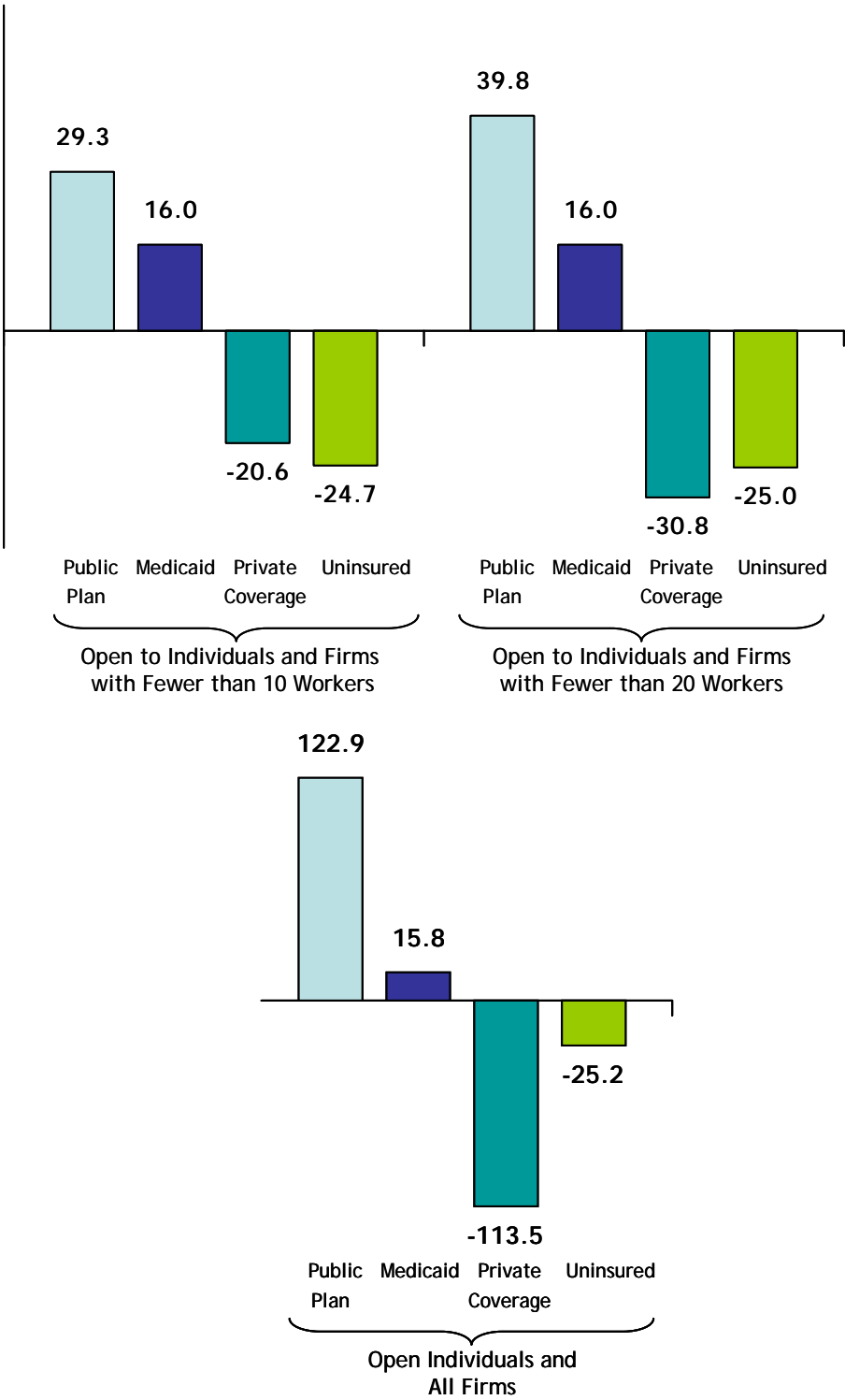
These shifts in coverage would differ depending upon the groups of firms that would be eligible to enroll. In the first year, the public plan would be open to individuals and firms with fewer than 10 workers. Under this scenario, 29.3 million people would be enrolled in the public plan (*Figure 7*) if fully implemented in 2010. The number of people with private coverage would fall by about 20.6 million people. The plan would cover a slightly larger number of the uninsured because a public plan using Medicare rates reduces the cost of insurance for eligible people.

In the second year of the program, the exchange and public plan become available to individuals and firms with fewer than 20 workers. If fully implemented in 2010, public plan enrollment would reach 39.8 million people, with the number of people covered under private coverage declining by 30.8 million people.

As discussed above, the bill leaves it to the Commissioner to specify the groups of firms that would be permitted to enroll in the public plan beginning in the third year of the program. To illustrate its potential impact, we estimated the effect on coverage in the third year of the program assuming the public plan is opened to individuals and all firms, the public plan would enroll about 122.9 million people (includes some uninsured who take coverage). The number of people with private health insurance would decline by about 113.5 million people (*Figure 7*). This is equal to about 66 percent of all people currently covered under private health insurance (excludes supplemental coverage for Medicare beneficiaries).²⁰

²⁰ In a recent study, we estimated that a public plan using Medicare payment rates would enroll about 131.0 million people with a reduction in private coverage of 119.1 million people. We estimate smaller public plan enrollment under the house bill because physician payment would be 5 percent higher than Medicare levels.

Figure 7
Changes in Sources of Coverage under the House Bill with Alternative Public Plan Eligibility Levels
in 2010 (millions)

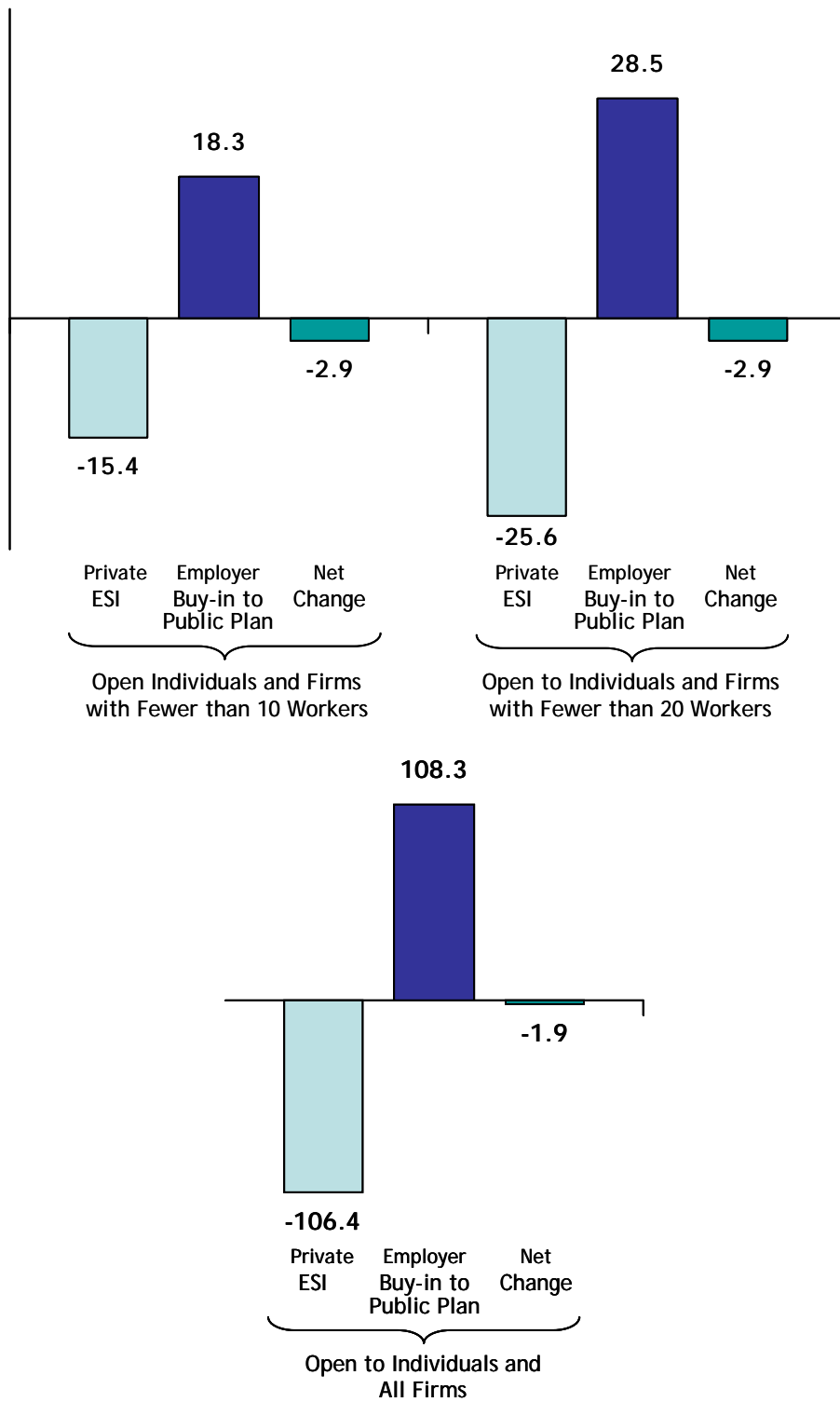


Source: Lewin Group Estimates.

Figure 8 presents the changes in employer coverage under alternative specifications of the public plan at various levels of provider payment. For example, under the scenario where the public plan is open to individuals and all employers, the number of people with private employer sponsored coverage would decline by 106.4 million people. However, employers would cover about 108.3 million workers and dependents under the public plan.

Thus the number of people in plans where the employer contributes to the cost of coverage would decrease by 1.9 million people. This reflects a net increase in the number of employers who sponsor coverage due to the employer pay-or-play requirements under the House bill proposal.

Figure 8
 Changes in Employer Coverage under the House Bill with Alternative Public Plan Models in 2010
 (millions)



Source: The Lewin Group estimates.

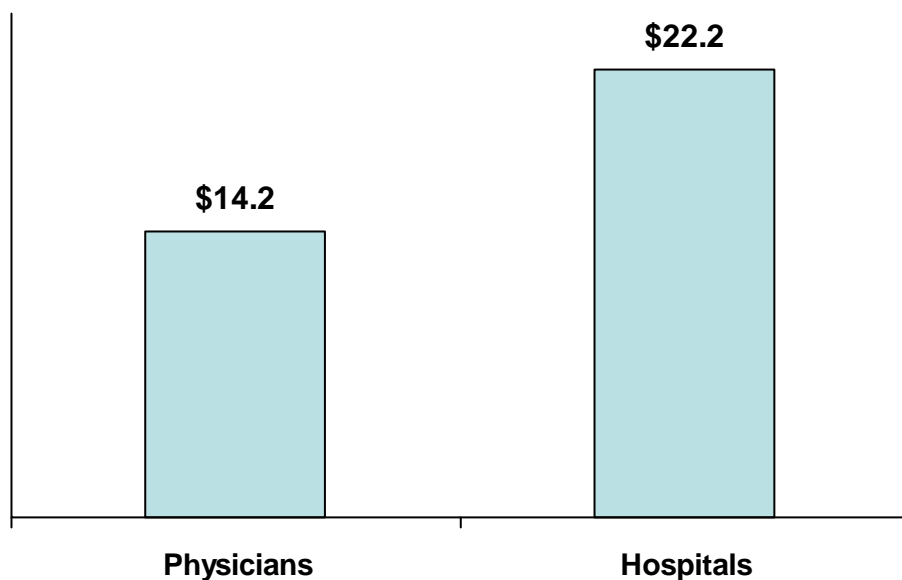
C. Provider Impacts

A health reform plan with a public plan would have a significant impact on provider net-incomes. Expanding coverage would reduce uncompensated care for uninsured people and increase health services utilization for the newly insured, all of which would represent new revenues to providers. Also, the House bill increases reimbursement for primary care providers under Medicaid, which would also increase provider income. However, these increases in revenues could be largely offset by reductions in payment levels for people who shift from private insurance to the public plan.

1. Net-income effects of Public Plan on Providers

If the House bill were to be implemented without a public plan, there would be a significant increase in provider revenues. Hospital net-income would increase by \$22.4 billion and physician net-income would increase by \$14.2 billion (*Figure 9*). This reflects that provider net income would generally increase due to: reduced uncompensated care; increased reimbursement under Medicaid for physicians (\$8.4 billion); and increased utilization of services for newly insured people. The change in net-income to providers would be similar if a public plan is used that pays providers at private payer levels.

Figure 9
Changes in Provider Net-Income under the House Bill without a Public Plan



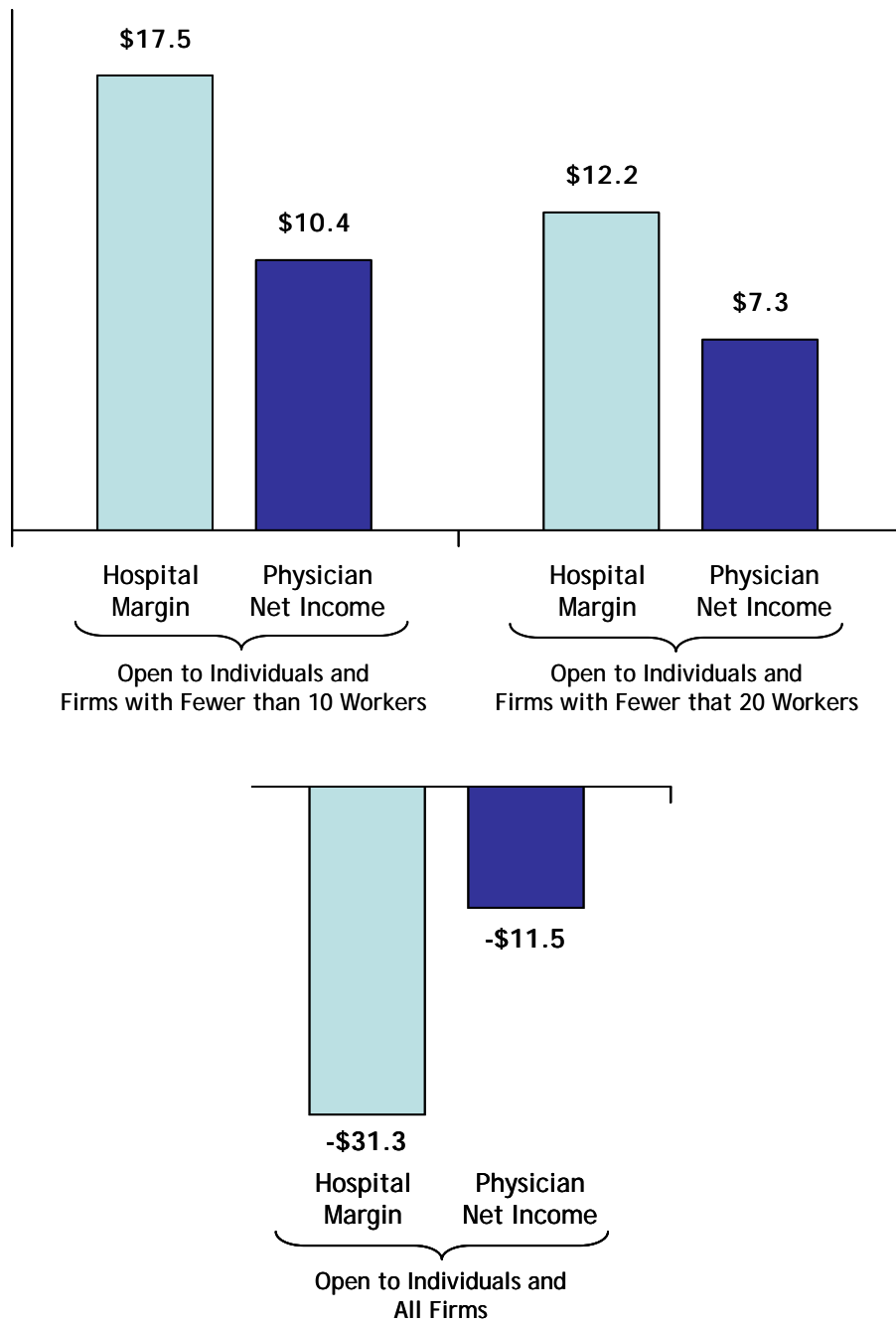
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The impact of the public plan on providers will vary depending upon the groups who become eligible to participate. In the first year, the plan would be open to individuals and firms with fewer than 10 workers. Under this scenario, hospital net income (also known as margin) increases by \$17.5 billion and physician net income increases by \$10.4 billion (*Figure 10*). In the

second year, where firms with fewer than 20 workers become eligible, hospital margin would increase by \$12.2 billion while physician income would increase by \$7.3 billion.

Provider incomes would decline if the public plan is opened to all firms in the third year of the program due to higher enrollment in the public plan. Under this scenario, hospital net-income would fall by \$31.3 billion in 2010 (*Figure 10*). Physician and other health professionals' net-income would fall by about \$11.5 billion under this scenario.

Figure 10
 Impact of Public Plan on Provider Income under Alternative Public Plan Models in 2010 (billions) ^{a/}



a/Includes changes in provider net-income due to increased utilization and reduced uncompensated care, payment level changes under the Medicaid expansion and changes in revenues due to the shift to the public plan.

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

The effect on provider income is substantially smaller under a scenario where large firms are excluded from participation in the public plan. For example, even if Medicare Payment rates are used in the public plan, hospital margin would actually increase by \$17.5 billion in 2010 as long as eligibility is limited only to individuals and small firms with fewer than 10 workers. Thus, the increased revenues for newly insured people (including reduced uncompensated care) are greater than the loss of revenues for people who shift from private coverage to the public plan. Physician income net of practice expenses would also increase by \$10.4 billion under this scenario.

2. Detailed Physician Impacts Estimates

We estimated the changes in physician revenues resulting from the five scenarios described above. Our estimates reflect reductions in uncompensated care resulting from expanded health insurance coverage, which represent a net increase in income to providers. 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 for the four scenarios (*Figure 11*).

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.²¹ The resulting data show the net change in physician revenues and net income under each of the public plan scenarios considered in this study.

Based upon data obtained from the American Medical Association, 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.^{22,23,24}

Physician net income would increase by an average of \$19,795 per physician if the House bill is implemented without a public plan (*Figure 11*). This includes increased net-income for services provided to newly insured people (i.e., increased revenues less additional practice expenses for newly covered). It also reflects payments received for care that would have been provided free to uninsured people under current law and the improvement in Medicaid payment rates for primary care providers under the bill.

If the public plan is open to individuals and all employers using Medicare payment levels plus 5 percent, physician revenues would fall by 1.0 percent (*Figure 11*). While physician revenues would decline, physician practice expenses would increase due to the cost of increased utilization for newly insured people. Thus, physician net income would fall by 5.4 percent. The

²¹ This is the assumption used by the Center for Medicare and Medicaid Services (CMS) in calculating outlier payments.

²² "Physician Characteristics in the US: 2007 Edition," American Medical Association

²³ "Physician Socioeconomic Statistics: 2000-2002 Edition," American Medical Association

²⁴ "Cost Survey for Multispecialty Practices: 2006 Report," Medical Group Management Association

loss of net-income under this scenario would average about \$16,207 per physician assuming the program is fully implemented in 2010.

Figure 11
Impact of Public Plan on Physician Revenues, Expenses and Net Income under the House Bill by Public Plan Eligibility Group in 2010

	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 (billions)				
Newly Utilization	\$11.0	\$11.3	\$11.5	\$11.6
Reduced Uncompensated Care	\$2.5	\$2.6	\$2.7	\$2.9
Increased Payments for Primary Care Under Medicaid	\$8.4	\$8.4	\$8.4	\$8.4
Payment Level Adjustment	-\$1.9 ^{a/}	-\$5.5	-\$9.3	-\$28.3
Net Change	\$20.0	\$16.8	\$13.3	-\$5.4
Physician Costs for New Health Services Utilization (billions)				
Costs for Newly Insured	\$5.8	\$5.9	\$6.0	\$6.1
Changes in Physician Net Income (billion)				
Change in Net Income	\$14.2	\$10.9	\$7.3	-\$11.5
Summary Impacts				
Percentage change in revenues	3.7%	3.1%	2.4%	-1.0%
Percentage change in net income	6.6%	5.0%	3.3%	-5.4%
Change in net income per physician in 2010	\$19,795	\$15,237	\$10,141	-\$16,207

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.

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

3. Detailed Hospital Impacts Analysis

We estimated the impact of the four alternative scenarios that we modeled on hospital net-income under the House bill. 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 2010. ^{25,26}

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 represent 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 12*).

Figure 12
Impact of Public Plan on Hospital Revenues and Expenses under the House Bill by Public Plan Eligibility Group in 2010

	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)				
Newly Utilization	\$12.5	\$12.8	\$13.1	\$13.2
Reduced Uncompensated Care	\$20.7	\$21.2	\$21.7	\$21.8
Payment Level Adjustment ^{a/}	-\$1.2	-\$11.3	-\$15.2	-\$62.5
Net Change	\$32.0	\$27.8	\$23.7	-\$20.8
Hospital Costs for New Health Services Utilization (billions)				
Costs for Newly Insured	\$10.0	\$10.3	\$11.5	\$10.5
Changes in Hospital Net Income (billion)				
Change in Net income	\$22.0	\$17.5	\$12.2	-\$11.5
Summary Impacts				
Percent Change in Net Income in 2010	44%	35%	24%	-63%
Total Hospital Margins in 2010 Under the Proposal (Estimated margin under current law = 6.0%)	8.6%	8.1%	7.4%	2.2%

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

²⁵ Centers for Medicare & Medicaid Services, June 11, 2009 at <http://www.cms.hhs.gov/nationalhealthexpenddata/>

²⁶ 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 \$49.9 billion in 2010 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 \$31.3 billion, which is a 63 percent reduction from what margin would be under current law (*Figure 12*). Total hospital margin would fall from 6.0 percent under current law to 2.2 percent.