

# Covering America

REAL REMEDIES  
FOR THE UNINSURED

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

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*Appendix E*

### **Medicare Plus: Increasing Health Coverage by Expanding Medicare**

by Jacob S. Hacker

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## The Medicare Plus Program by Jacob Hacker

Jacob Hacker proposes to create a public health insurance program called “Medicare Plus.” Coverage under the plan would be available to all legal residents not otherwise covered by Medicare or employer-sponsored insurance (ESI). Under this proposal, employers would be required to either provide a minimum level of coverage to their workers or pay a payroll tax. Workers and their dependents in firms that choose to pay the tax would be covered under the Medicare Plus program. Individuals covered under the Medicare Plus program would also pay an income-related premium. Medicaid coverage would be folded into the Medicare Plus program.

In this paper we summarize the key provisions of the author’s proposal and describe the key assumptions used to estimate its impacts. We also present our estimates of the cost and coverage impacts of this proposal.

### A. The Medicare Plus Proposal

#### 1. Medicare Plus Benefits Package

- The Medicare Plus benefits package would be based on the current Medicare benefits package, which would be improved to include coverage for:
  - Outpatient prescription drugs;
  - Preventive services;
  - Mental health services; and
  - Maternity and child health.
- The benefits package would include a single deductible, co-payments, and a cap on out-of-pocket spending. The program would have a deductible of \$250 per person (\$500 per family), 20 percent coinsurance on outpatient services and \$15 per prescription up to a maximum out-of-pocket amount of \$2,500 per person (\$5,000 per family). The deductible would apply to prescription drugs.
- The benefits package would be reviewed annually by an advisory board.
- Benefits for current Medicare recipients would remain the same as they are today.
- Medicare reimbursement levels would be used under the program which implies:
  - Higher payments for persons otherwise covered under Medicaid;
  - Lower payments for persons joining Medicare Plus who otherwise would have had private coverage.
- Medicare would receive rebates for drugs equal to those obtained under the current Medicaid program (about 18 percent) with a formulary.

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- Participants in the Medicare Plus program would be permitted to take coverage under Medicare+Choice plans as under the current Medicare program. Payments to plans would be adjusted to reflect the demographic profile of Medicare Plus participants and the benefits offered under the program.

## **2. Employer Requirements**

- Employers would be required to either provide coverage at least as comprehensive as the Medicare Plus package or pay a payroll tax. The plan must meet the following criteria:
  - Benefits must be at least actuarially equivalent to the Medicare Plus benefits package;
  - For persons working over 20 hours per week, the employer must pay three-quarters of the single premium and two-thirds of the family premium; and
  - Persons working 20 hours or less per week, the employer must pay half of the premium.
- Workers and dependents in firms that chose to pay the tax would be covered automatically under Medicare Plus.
- Employers would be permitted to vary the coverage decision by class of worker as they do now. For example, an employer could provide coverage to their full-time workers and pay the tax for part-time workers.
- The payroll tax would be equal to five percent of social security covered earnings amounts for persons who are not offered employer coverage.
- Firms not offering health insurance at the time of implementation would be provided with transitional rates that are 1.5-percentage points less than the rates they are otherwise required to pay. This reduction would phase-out over a period of 10 years.
- Self-employed persons must either pay an employment income-based tax computed as above, or show that they are covered under a plan conforming to at least the Medicare Plus benefits plan.

## **3. Individual Responsibility**

- All individuals not already covered under the current Medicare and/or CHAMPUS programs must have insurance.
- Coverage is automatic for workers and dependents in firms that choose to pay the payroll tax rather than provide coverage. For these individuals, including the self-employed, there would be a monthly premium of:
  - \$50 for single coverage
  - \$100 for couple coverage
  - \$90 for single parent with children
  - \$140 for married couples with children

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These amounts would be indexed by the growth in per-capita costs under the Medicare Plus program.

- Individuals and families with incomes below 200 percent of the federal poverty level (FPL) would pay no premium, with the premiums phased in on a sliding scale for those with incomes between 200 percent and 300 percent of the FPL.
- Persons below 100 percent of the FPL would be eligible for a reduction in co-payments, which are equal to the “nominal” co-pays under the current Medicaid program. Co-pays are phased-in between 100 percent of the FPL and 150 percent of the FPL.
- Individuals not in the workforce would be permitted to purchase Medicare Plus coverage by paying an income-related premium. The premium for this group is equal to the full average actuarial cost of the plan. The premium would not vary by age or other risk factors. There would be no premium for persons below 200 percent of the FPL, with the premium phased-in on a sliding scale with income between 200 percent and 300 percent of the FPL.
- Any individual may opt out of Medicare Plus by showing proof of alternative coverage that meets the minimum benefits standard. The private plan chosen by the individual would receive 80 percent of the payroll tax paid for the individual, thus partly offsetting the cost of the private coverage to the individual. This choice is permitted at either initial enrollment or during a limited open enrollment period.

#### **4. Spousal Coverage in Two-Worker Families**

- If both of the workers’ employers have paid the tax, both are covered under Medicare Plus (with dependent children) and would pay the couple/family premium as a single-family unit.
- If one spouse’s employer pays the tax while the other provides coverage, the family could do one of three things:
  - The worker with private coverage could elect to cover his or her spouse under that plan. In this case, the Medicare Plus rebates to the insuring employer 100 percent of the tax paid by the other spouse’s employer;
  - The worker with private coverage could decide to take coverage with his or her spouse under Medicare Plus. In this case the insuring employer must pay the payroll tax for the worker who has elected to be covered under Medicare Plus; or
  - Each could decide to take coverage as single individuals (possibly one as a single parent) on the coverage associated with each of these workers (i.e., private for one and Medicare Plus for the other).

#### **5. Disposition of Medicaid**

- Medicaid would be retained for the aged and disabled populations.

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- Medicaid and S-CHIP would be eliminated for the acute care population (i.e., non-aged non-disabled);
  - Persons who currently qualify for Medicaid under the medically needy spend-down provisions would become covered under this proposal and would no longer spend-down for acute care services. (As discussed below, the Medicaid program would be retained for long-term care).
  - Medicare Plus would assist low-income persons with their co-payments as described above.
  - Wrap-around benefits are provided for persons formerly eligible under Medicaid for services that were provided under Medicaid but are not covered under the Medicare Plus benefits package. These services include:
    - EPSDT
    - Long-term care
    - Transportation
    - Other non-Medicare services
  - Federal funding for Disproportionate Share Hospital (DSH) payments would be reduced in proportion to the reduction in uncompensated care.

## **6. Cost Control**

The program would cap the rate of growth in per-capita health spending for persons covered in the public plan so that it does not grow more rapidly than the per-capita nominal growth in the gross domestic product (GDP) plus one percentage point.

## **7. Financing**

- Program financing includes:
  - Payroll tax payments
  - Premium payments
  - Medicaid acute care funding (both state and federal shares)
- The amount of the exclusion for employer-provided health benefits would be capped at an amount equal to twice the level of Medicare Plus premiums.
- Supplemental plans provided to employers whose workers enrolled in Medicare Plus would not be tax-exempt.
- Savings from reduced Medicaid Disproportionate Share Hospital (DSH) payments.
- The plan does not specify how the remainder of the funds required for this program would be raised. We assume that these funds would be raised through an increase in the personal income tax.

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- Both the payroll tax rate and premium levels are indexed to the rate of growth in nominal GDP plus 1.0 percentage point.

## **B. Key Assumptions**

These estimates were developed using the Lewin Group Health Benefits Simulation Model (HBSM). The model is based upon a several data sources including the 2001 Current Population Survey (CPS), the 1996 Medical Expenditures Panel Survey (MEPS), and the 1999 survey of employers conducted by the Kaiser Family Foundation and the Health Research and Education Trust (HRET). The data and methods used are presented in **Appendix A** of this report.

A summary of the key assumptions used in this analysis is presented below.

### **1. Universality**

Enrollment would be automatic for all workers and their dependents. All workers would be required to take the coverage offered by their employers if employers decide to provide insurance rather than pay the tax. Enrollment of workers and dependents in public programs also would be automatic resulting in universal coverage for the employed population and their dependents.

Among non-workers, we assume that enrollment rates will be similar to those in the existing Medicaid/SCHIP program (about 70 percent for uninsured persons). This assumption reflects the fact that no penalties are specified for persons failing to secure coverage. This assumption results in less than universal coverage for non-workers and for workers during periods where they are unemployed or out of the labor force.

### **2. Employer Coverage Decision**

The model simulates the employer's decision to purchase coverage or pay the tax based upon the cost of these two approaches to the employer. Firms that find that the cost of the minimum standard benefits package for their workers is less than the cost of paying the payroll tax are assumed to provide coverage. This would typically occur among firms with more highly compensated workers. Firms with lower-wage workers who find that paying the tax is less costly than providing coverage would pay the tax, thus covering their workers under the public program. The methods used to simulate the employer's decision are presented below.

**Creation of Synthetic Firms:** The simulation of the employer coverage decision was based upon a database of "synthetic firms" developed using HBSM. Each worker in the MEPS data was assigned to one of the employers in the 1999 Kaiser/HRET data. We then "populated" the firm to which each worker has been assigned by randomly selecting MEPS workers who match the economic and demographic profile of persons employed by that firm.<sup>1</sup>

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<sup>1</sup> The Kaiser/HRET data provide information on the wage profile, industry and firm size characteristics of each firm. We then statistically matched these data with the 1991 employer survey conducted by the Health Insurance Association of America (HIAA), which provides additional demographic detail including age, gender, part-time/full-time status, and family/single covered status.

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For example, the firm assigned to a given MEPS worker that has 5 employees would be populated by that worker plus another four MEPS workers chosen at random who also fit the employer's worker profile. If this individual is in a firm with 1,000 workers, they are assigned to a Kaiser/HRET employer of that size and the firm is populated with that individual plus another 999 MEPS workers. This process was repeated for each worker in these data to produce one synthetic firm for each MEPS worker.

Health care costs for the group are assumed to be equal to the individual worker's costs as reported in MEPS plus the costs for other persons assigned to the firm. Costs also include expenditures for dependent spouses and children. This approach assures that the costs for each synthetic firm reflects the actual level of utilization for each MEPS worker, plus the others assigned to the firm.<sup>2</sup>

**Private Sector Premiums:** The model was used to estimate the premium for each of these synthetic firms under the federally defined minimum standard benefits package. The cost of covering these services was estimated from the health expenditures data reported for each of the workers assigned to the firm. Premiums were estimated based on a simulation of rating practices for firms of various sizes that apply in each state. The private coverage premium for each synthetic firm is estimated as follows:

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

Separate premiums are estimated for the various types of coverage (i.e., single, family etc.). These estimates are done for firms that currently offer insurance and firms that do not insure.

**Employer Choice:** We simulated the decision to pay the tax or provide the coverage based upon the data developed for each synthetic firm. For each firm, the cost of providing the minimum benefits package is based upon the premiums estimated as described above. Premiums reflect the cost of covering workers and dependents for workers in the firm who have families. The cost of paying the tax is computed on the basis of earnings reported for workers assigned to each firm.

We assume that the employer offers the coverage if it is less costly than paying the tax. In some instances, insuring employers will need to upgrade their coverage to the minimum standard

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<sup>2</sup> The method for developing synthetic firms is described in detail in appendix A to this report.

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benefits package as discussed below. All others pay the tax, thus covering their workers and dependents under the public program.

**Actuarial Equivalence:** Some of the insuring employers who would choose to continue to provide coverage would need to upgrade their benefits package to the minimum standard. We estimate the number of such employers based upon information on the plan characteristics data provided in the employer data. These data provide a limited amount of information on coverage for various services, and patient cost sharing, which we used to estimate the actuarial value of each employer plan using actuarial cost factors developed using HBSM. This approximation of the actuarial value of each plan reflects the cost impacts of covering various services (dental, drugs etc.) under different coinsurance requirements (deductibles, coinsurance etc.).<sup>3</sup>

### **3. Re-Estimation of Benefits**

We estimated covered benefits for persons who would become covered under the Medicare Plus benefits package. This was done for all persons assigned to firms that decide to pay the tax. We also recomputed benefits for persons in firms with substandard coverage that decide to upgrade their benefits and continue to sponsor coverage. These re-computations of benefits were done using the detailed health expenditures data reported for individuals in the MEPS data.

### **4. Spousal Coverage in Two-Worker Families**

As discussed above, two-worker couples/families would have a choice in cases where one spouse's employer decides to offer coverage while the other's decides to pay the tax. In these instances, we assumed that the worker with the private coverage would elect to cover their spouse as a dependent. As discussed above, this would require the public program to transfer to the private employer the amount of the tax paid by the dependent spouse's employer.

### **5. Other Employer Responses**

Additional employer behavior assumptions include:

**Wage effects** - Increases in employer costs are assumed to be passed on to employees in the form of reduced wages. This automatically affects tax revenues from income and sales taxes. We assume that changes in employer costs for retiree health benefits would not be passed on to workers as changes in wages. This is because retiree benefits costs are related to prior employer commitments that have little impact on the current labor markets. Thus, savings in retiree benefits are assumed to accrue to the employer.

**Employer supplemental coverage:** Employers are assumed to provide supplemental coverage for services that they now cover under their plans, which would not be covered under the

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<sup>3</sup> Because the benefits data provided in the Kaiser/HRET data is limited, we statistically matched these data to the 1991 survey of employers conducted by the Health Insurance Association of America (HIAA), which provides additional benefits information (e.g., dental, prescription drugs etc.) in addition to information on the economic and demographic characteristics of employees of the firm.

Program. These services typically include adult dental, orthodontia and eyeglasses. As discussed above, these benefits would no longer be exempt from the personal income tax.

## 6. Changes in Provider Payment Rates

The Medicare Plus program would reimburse providers at Medicare payment levels for all persons covered under the program. This implies that payment levels for services now provided to Medicaid recipients would adjust (usually increase) to Medicare levels as this population (excluding aged and disabled) is shifted to the Medicare Plus program. Similarly, provider payment levels for services provided to privately insured persons who would become covered under Medicare Plus would adjust (usually downward) to Medicare payment levels. This would include persons in firms that decide to pay the tax and persons with private non-group policies who would join the Medicare Plus program.

We simulated these changes in provider payments based upon recent studies of relative differences in provider payment rates by type of payer. *Figure 1* presents estimates of payments as a percentage of costs by payer, which were used as the basis of our simulation of changes in provider reimbursement levels.

**Figure 1**  
**Provider Payments as a Proportion of Medicare Payments by Payer Type**

<u>Payer Type</u>	<u>Hospital Care</u> <sup>a/</sup>	<u>Physician Care</u>
Medicare	1.00	1.00
Medicaid	0.95	0.64 <sup>b/</sup>
Private Coverage	1.16	1.41 <sup>c/</sup>

a/ "TrendWatch Chartbook 2001", American Hospital Association (AHA).

b/ Norton, Stephen, "Recent Trends in Medicaid Physician Fees", The Urban Institute, 1993-1998.

c/ "Physician Payment Review Commission, Annual Report to Congress, 1996"

Source: Lewin Group assumptions.

## 7. Administrative Costs

Administrative costs in the public plan were estimated based upon an estimate of administrative costs under an employer pool with one health plan, which in this case would be the Medicare Plus program. These data indicate that administrative costs as a percentage of benefit payments would range between 3.5 percent for firms with 10,000 or more workers to 11.0 percent for "groups" with 1 to 4 workers.<sup>4</sup> These estimates reflect the fact that there will continue to be economies of scale for larger groups that would be covered under the public plan. Administrative costs are assumed to equal 11 percent of claims for all non-working individuals.

We also assumed that administrative costs for Medicaid recipients who are shifted to private coverage through the public plan would be 11 percent. However, we assumed that this increase

<sup>4</sup> "Costs and Effects of Extending Health Insurance Coverage", Congressional Research Service (CRS), Hay/Huggins inc., Washington DC, October 1988. We excluded Risk/Profits and premium taxes from the author's estimates to reflect that the Medicare Plus program would be a federal program.

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in administrative costs would occur among only the portion of Medicaid beneficiaries who are not already enrolled in private managed care plans.

It is difficult to estimate the cost of administering the premium and cost sharing subsidies under the program. For illustrative purposes, we assume that the cost of processing eligibility for subsidies for individuals would be equal to what it is under the current Medicaid program, which we estimate to be about \$190 per family per year. For persons with employer coverage, the cost of administering the subsidy is assumed to be half that amount, reflecting that under the proposal, the employer would assist in these functions.

## **C. Cost and Coverage Impacts**

We present our estimates in two ways. First, we present estimates of the cost and coverage impacts of each provision of these proposals assuming the program is fully phased-in and implemented in 2002. These estimates are useful for comparing program impacts at the current levels of the uninsured and health care costs. However, we expect enrollment to lag for up to two years as individuals learn about the program and begin to apply for these subsidies. Consequently, for budgetary purposes, we also present year-by-year cost estimates for 2003 through 2012, which reflect these expected lags in enrollment.

These results are presented in the following sections:

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

### **1. Sources of Coverage**

The plan would reduce the number of uninsured by about 37.0 million persons. This is a reduction of about 88 percent from our estimate of 41.9 million uninsured persons (average monthly count) in 2002.<sup>5</sup> Those who remain uninsured would be non-workers or workers during periods of non-employment who decide not to seek benefits under the program, despite the requirement to do so.

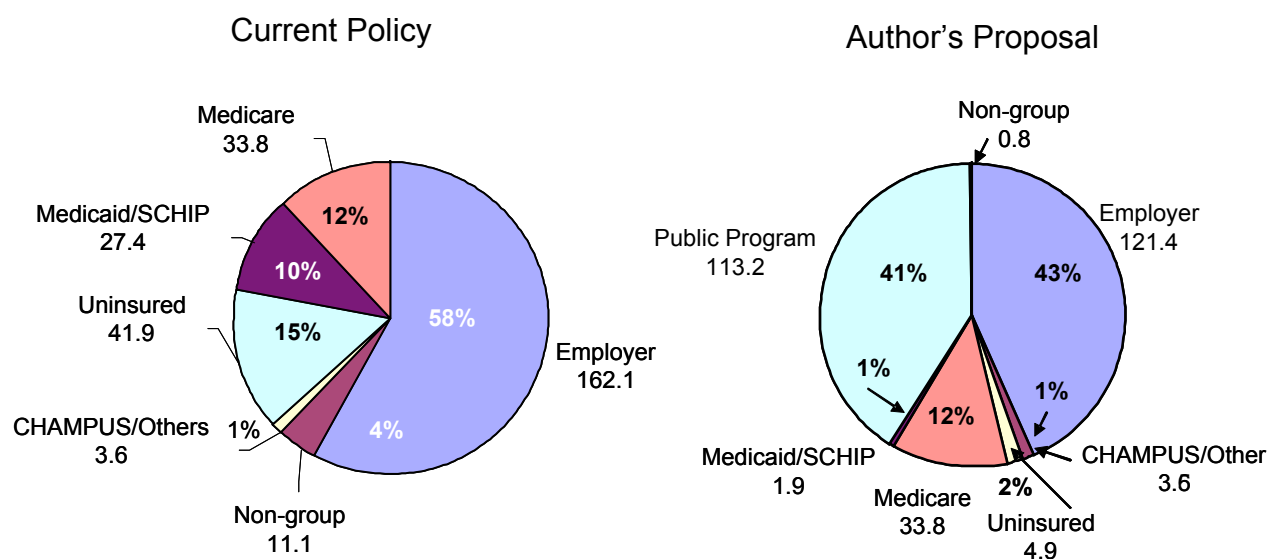
The author's proposal would change the source of insurance coverage for many non-elderly Americans. Based upon our simulation of employer and consumer decision making described earlier, we estimate that there would be about 113.2 million persons enrolled in the public plan (*Figure 2*). These include:

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<sup>5</sup> All population counts in this analysis represent average monthly enrollment by coverage source.

- Medicaid and SCHIP enrollees shifted to the public plan;
- Workers and dependents in employer plans whose employers decide to pay the tax rather than provide coverage;
- Workers and dependents in currently non-insuring firms that decide to pay the tax rather than offer coverage;
- Persons with non-group coverage who enroll in the public plan; and
- Currently uninsured persons not associated with employment who obtain coverage.

**Figure 2**  
**Distribution of Persons by Primary Source of Coverage under Current Policy and the Author's Proposal in 2002<sup>a/</sup> (in millions)**



**Total Population = 279.9 million persons**

a/ Coverage presented on an average monthly basis.

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

Coverage in employer-sponsored plans would decline from 162.1 million persons under current law to 121.4 million persons under the author's proposal. This decline in employer coverage reflects the fact that the payroll tax under the program would be less than the cost of insurance for about a third of the employers who now offer insurance. Private non-group coverage (currently 11.1 million persons) would be virtually eliminated as these individuals become covered through employment or enroll in the public plan.

The number of persons with Medicaid/SCHIP as their primary source of coverage (i.e., excludes Medicare dual eligible enrollees) would decline from about 27.4 million to 1.9 million persons. Those who continue to have Medicaid as their primary source of insurance would be a small number of aged persons who do not qualify for Medicare.

Figure 3 summarizes the transitions in sources of coverage under the author's plan.

**Figure 3**  
**Coverage Transitions Under the Author's Proposal (in millions)**

Base Case Coverage	Primary Sources of Coverage Under Proposal								
	Total	Public Program		Private Coverage		Other Sources			
		Employer	Individual	Employer	Non-group	CHAMPUS	Medicare	Medicaid	Uninsured
<b>Employer</b>	<b>162.1</b>	54.7	0	107.4	0	0	0	0	0
<b>Non-Group</b>	<b>11.1</b>	5.2	2.6	2.5	0.8	0	0	0	0
<b>CHAMPUS</b>	<b>3.6</b>	0	0	0	0	3.6	0	0	0
<b>Medicare</b>	<b>33.8</b>	0	0	0	0	0	33.8	0	0
<b>Medicaid</b>	<b>27.4</b>	5.0	18.8	1.7	0	0	0	1.9	0
<b>Uninsured</b>	<b>41.9</b>	20.7	6.5	9.8	0	0	0	0	4.9
<b>Total</b>	<b>279.9</b>	<b>85.6</b>	<b>27.9</b>	<b>121.4</b>	<b>0.8</b>	<b>3.6</b>	<b>33.8</b>	<b>1.9</b>	<b>4.9</b>

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

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## 2. *Impact on National Health Expenditures*

Health expenditures in the United States are projected to reach about \$1.5 trillion in 2002. We estimate that national health spending would increase by about \$32.3 billion under the author's proposal. Payments for health services would increase by about \$30.3 billion due to increased access to health services for newly insured persons and various effects of the program on utilization and provider reimbursement. Administrative costs would increase by about \$2.0 billion. Insurer administrative costs would actually decline as persons with coverage are shifted to a single public program that does not incur the marketing and risk premium costs found in private health insurance plans. However, the reduction in insurer administrative costs is more than offset by the cost of administering the premium and cost sharing subsidies.

The increase in payments to providers for health services (\$30.3 billion) includes the cost of increased health services utilization and changes in reimbursement rates under the program. Utilization of health services among newly insured persons and persons with improved coverage would increase by about \$30.3 billion (*Error! Not a valid bookmark self-reference.*). This includes \$22.3 billion in increased spending for newly insured persons and about \$8.0 billion in spending for persons who would become covered under a more comprehensive benefits package.

Spending would increase by an additional \$3.0 billion due to changes in provider reimbursement. Provider payment rates for services on average would decline by about \$10.2 billion due to the use of Medicare Payment rates in the public program. This reflects:

- The reduction in payments for care provided for persons who are shifted from private coverage to the public plan where Medicare payment rates are used; and
- Increases in reimbursement for services provided to Medicaid recipients who are shifted to the public program (Medicare payment rates typically exceed Medicaid rates).

In addition, a portion of the care that is now provided as uncompensated care would become reimbursable due to the insurance expansion resulting in an additional increase in provider income of about \$15.2 billion. We assume that about 40 percent of the \$5.0 billion net increase in provider payments would be passed on to private health plans in the form of reduced cost-shifting (\$2.0 billion), resulting in a total net increase in provider revenues of \$3.0 billion. Spending would be reduced by \$3.0 billion as federal funding for Medicaid DSH is reduced in proportion to the reduction in uncompensated care

As discussed above, administrative costs would increase by about \$2.0 billion. Insurer administrative costs would decline by about \$4.6 billion as large numbers of persons with private coverage are shifted to the public plan. The cost of insurer administration in the public plan would be less than in the private market because all individuals would be covered under a single insurance program with a uniform benefits package. This is substantially less costly than administration of private insurance because there would be no marketing costs or risk premium (profit) and there would be only one benefits package with uniform provider reimbursement and utilization review requirements. These administrative savings would be more than offset by the cost of administering premium and cost sharing subsidies for families (\$6.6 billion) resulting in a net increase in administrative costs of \$2.0 billion.

**Figure 4**  
**Changes in National Health Spending Under the Author's Proposal in 2002**  
(in billions)

<b>Change in Health Services Expenditures</b>		<b>\$30.3</b>
Change in utilization for newly insured	\$22.3	
Change in utilization due to improved coverage	\$8.0	
Reimbursement Effects	\$3.0	
Changes in provider reimbursement	(\$10.2)	
Payments for uncompensated care	\$15.2	
Reduced cost shifting	(\$2.0)	
Federal Medicaid DSH spending	(\$3.0)	
<b>Change in Administrative Costs</b>		<b>\$2.0</b>
Insured administration	(\$4.6)	
Administration of subsidies	\$6.6	
<b>Total Change in Health Spending</b>		<b>\$32.3</b>

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

*Figure 5* summarizes how these changes in spending are distributed over major stakeholder groups. Initially, federal spending on health care would increase by about \$90.6 billion. Spending for private employers would actually decline by about \$1.5 billion, reflecting the fact that many firms would find it less costly to pay the tax rather than provide insurance. Economic theory and evidence indicate that wages would adjust over time to reflect the decline in employer health benefits expenditures. These wage effects would result in another \$1.3 billion in savings to households. Households and state and local governments would on average see savings.

**Figure 5**  
**Change in Health Spending by Stakeholder Group in 2002 (in billions)**

	Without Wage Effects	With Wage Effects	With Wage Effects and Fully Financed
<b>Federal Government</b>	\$90.6	\$87.5	--
<b>State and Local Government</b>	(\$14.4)	(\$11.5)	(\$11.5)
<b>Private Employers</b>	(\$1.5)	--	--
<b>Households</b>	(\$42.4)	\$(43.7)	\$43.8
<b>Total Health Spending</b>	<b>\$32.3</b>	<b>\$32.3</b>	<b>\$32.3</b>

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

These savings to households would be more than offset by an increase in the personal income tax to cover the federal cost of the program. Thus, households would actually pay nearly all of the cost of the increase in national health spending. The impact on various stakeholder groups is presented below in greater detail.

### 3. Program Spending

Total program spending would be \$159.3 billion if fully implemented in 2002 (*Figure 6*). Program spending would include about \$17.6 billion in premium subsidies for employees in private plans and about \$13.9 billion in cost sharing subsidies. The cost of coverage less premium collections net of subsidies would be about \$127.8 billion.

These estimates reflect the fact that the current Medicaid and SCHIP coverage for non-disabled non-aged persons would be folded into the public program.<sup>6</sup> However, the Medicaid program would be retained in its current form for aged and disabled persons, and long-term care. Federal disproportionate share hospital payments would also be reduced in proportion to the reduction in uncompensated care (35%). Total spending for these elements of the program would be \$163.0 billion (*Figure 6*).

The combined cost of the newly created public plan and the continued portions of Medicaid would be \$322.3 billion if fully implemented in 2002. The federal matching rates for the portion of the Medicaid programs that are retained would be the same as under the current Medicaid program. Of the \$322.3 billion in spending under these programs, the federal government would pay \$253.2 billion with the states paying the remainder of \$69.1 billion.

**Figure 6**  
**Expenditures under Public Plans and Continued Medicaid Programs (in billions)**

	Total	Federal	State
<b>Public Plan Costs</b>			
Premium Subsidies (income eligible employees in firms that do not pay tax)	\$17.6	\$17.6	\$0.0
Cost sharing Subsidies	\$13.9	\$13.9	\$0.0
Public Program Operations:	\$127.8	\$127.8	\$0.0
Benefits	\$229.5		
Insurer Administration	\$17.7		
Administration of Subsidies	\$6.6		
Payroll tax & Premium Revenues (counted as an offset)	(\$126.0)		
<b>Subtotal Program Costs</b>	<b>\$159.3</b>	<b>\$159.3</b>	<b>\$0.0</b>
<b>Continued Medicaid Program</b>			
Aged and Disabled	\$57.1	\$32.0	\$25.1
Long-term Care	\$56.1	\$31.5	\$24.6
DSH (Federal only) <sup>/a</sup>	\$5.8	\$5.8	\$0.0
Other (including Wrap-Around Coverage)	\$30.3	\$17.0	\$13.3
Administration	\$13.7	\$7.7	\$6.0
<b>Subtotal Continued Medicaid Program</b>	<b>\$163.0</b>	<b>\$93.9</b>	<b>\$69.1</b>
<b>Total Program Costs</b>			
<b>Total Program Costs</b>	<b>\$322.3</b>	<b>\$253.2</b>	<b>\$69.1</b>

a/ Assumes federal spending for Medicaid DSH is reduced in proportion to uncompensated care (35%).

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

<sup>6</sup> Spending for the acute care population would be about \$66.9 billion in 2002, including benefits and administration.

#### 4. Federal Expenditures

Total federal spending under the program would be \$253.2 billion if implemented in 2002. This includes the federal share of all subsidies provided through the public plan and the federal cost of the portions of Medicaid that would continue under the proposal (*Error! Not a valid bookmark self-reference.*).

**Figure 7**  
**Changes in the Federal Spending Under the Author's Proposal (in billions)**

		Change in Spending
Federal Share of Spending under Program		
Public Plans	\$159.3	\$253.2
Continued Medicaid	93.9	
<b>Offsets</b>		
Current Medicaid Funding (Federal)		\$131.9
State Maintenance of effort (Medicaid/SCHIP)		\$26.7
Other Program Offsets		\$2.3
Cap on employer health benefits tax exclusion		\$0.5
Elimination of tax exclusion for employer supplemental plans for Medicare Plus enrollees		\$1.2
Revenues Due to Wage Effects		\$3.1
<b>Total Offsets</b>		<b>\$165.7</b>
<b>Net Cost to Federal Government</b>		
<b>Amount Raised through Income Tax Increase</b>		<b>\$87.5</b>

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

The program would be partly financed with the \$131.9 billion in funds that would have been used for the Medicaid and SCHIP programs in 2002. The program would receive about \$26.7 billion under a state maintenance of effort requirement obligating states to allocate to the program the amount that they would have spent under Medicaid and SCHIP for persons who become covered under the new public program. The cap on employer health benefits tax exclusion and elimination of the tax exclusion for employer supplemental plans for Medicare Plus enrollees would increase federal revenues by about \$1.7 billion. The federal government would also see an increase in federal income and payroll tax revenues of about \$3.1 billion due to the increase in wages resulting from reduced employer health benefits costs under the proposal. Total revenues and offsets from all sources would be \$165.7 billion, leaving about \$87.5 billion to be raised through an increase in the personal income tax.

#### 5. Impact on State and Local Governments

The state share of costs under the program would be \$95.8 billion. This includes the state share of costs for the portions of Medicaid that are retained under the plan (\$69.1 billion), and the maintenance of effort payment to the public program (\$26.7 billion). (States are required to forward to the program the amount that would have been spent under the portions of the program that are folded into the public plan). However, state and local governments would also

see savings of about \$10.8 billion in other safety-net programs for the medically indigent as the number of uninsured is reduced (*Figure 8*).

**Figure 8**  
**Change in Health Spending for State and Local Governments**  
**Under the Author's Plan**

	Change in Spending
State Share of Program Spending	\$95.8
Continued Medicaid      \$69.1	
Maintenance of Effort      \$26.7	
<b>Offsets</b>	
Current Medicaid Funding	\$95.8
Savings to Other Safety-net Programs	\$10.8
State and Local Worker Health Benefits Savings/(Increase)	\$0.0
Savings for Workers and Dependents      \$3.4	
Savings for Retirees      \$0.0	
Wage Effect Offset      (\$3.4)	
Cap on employer health benefits tax exclusion and Elimination of tax exclusion for employer supplemental plans	\$0.2
Tax Revenue from Wage Effect	\$0.5
<b>Total Offsets</b>	<b>\$107.3</b>
<b>Net Cost to State and Local Governments</b>	
<b>Net Savings</b>	<b>\$11.5</b>

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

State and local governments would have the option of covering their workers under the public plan. This would tend to occur in cases where the public plan premium is less than what the state would pay for private coverage. We estimate that total savings to state and local governments would be \$3.4 billion. However, as discussed above, we assume that these savings are eventually passed on to workers in the form of higher wages, with little net impact on state spending. Thus, we show no net change in state and local government spending for worker health benefits.

The cap on employer health benefits tax exclusion and elimination of the tax exclusion for employer supplemental plans for Medicare Plus enrollees would increase revenues for state with income taxes by about \$0.2 billion.

In addition, state and local governments with income taxes would see reduced tax revenues resulting from the wage effect for affected workers. Total net savings to state and local governments including revenue offsets would be about \$11.5 billion.

## 6. Private Employer Impacts

We estimate that private employers will spend about \$284.3 billion on health benefits in 2002 (*Figure 9*). This includes total benefits and insurer administrative costs less employee premium contributions. Private employer spending (i.e., \$284.3) includes about \$264.7 billion in spending for workers and dependents and \$19.5 billion in retiree benefits.

We estimate that health spending among firms that currently provide coverage would decline by about \$34.6 billion under the program. This includes savings from employers who shift to the public plan in cases where the public plan premium is less than what they would pay for comparable coverage in the private market. Total costs for firms that do not now offer coverage would be about \$33.1 billion. This includes premium payments for employers who decide to offer coverage, and payroll taxes among firms that decide to pay the tax.

Thus, the net impact of the program would be a decrease in private employer spending of \$1.5 billion. The average savings for private employers that currently offer coverage would be about \$409 per worker. The average cost per worker in firms that do not now offer insurance would be \$1,124 per worker. *Figure 10* presents the average change in costs per covered worker by firm size.

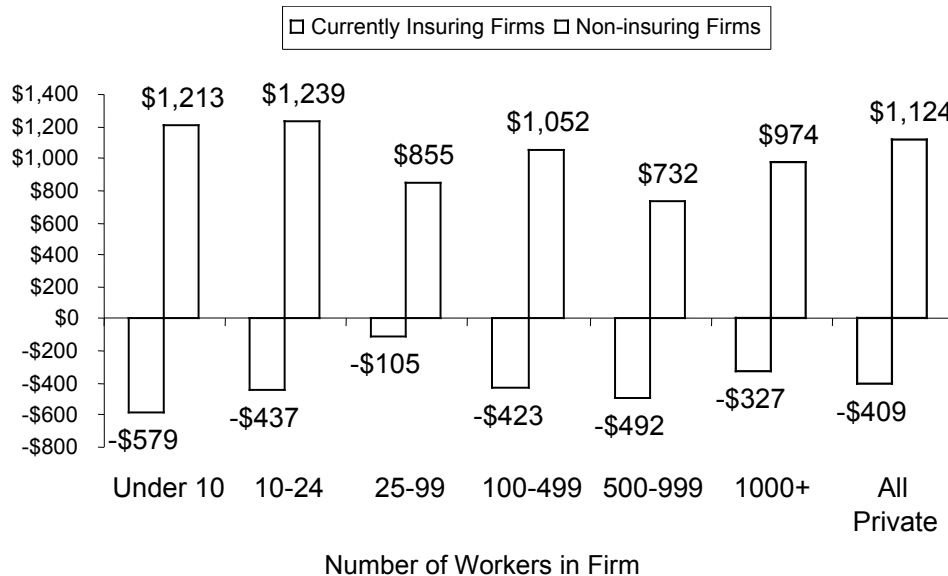
**Figure 9**  
**Changes in Private Employer Health Benefits Costs by Current Insuring Status in 2002 (in billions)**

	Insuring	Non-insuring	Total
<b>Private Employer Spending Under Current Policy</b>			
<b>Current</b>			
<b>Workers &amp; Dependents</b>	\$264.7	--	\$264.7
<b>Retirees</b>	\$19.5	--	\$19.5
<b>Total</b>	<b>\$284.3</b>	--	<b>\$284.3</b>
<b>Private Employer Spending Under the Policy</b>			
<b>Health Benefits Under Policy</b>			
<b>Workers &amp; Dependents</b>	\$185.7	\$2.4	\$188.1
<b>Retirees</b>	\$19.5	--	\$19.5
<b>Payroll tax Payments <sup>/a</sup></b>	\$44.5	\$30.7	\$75.2
<b>Total</b>	<b>\$249.7</b>	<b>\$33.1</b>	<b>\$282.8</b>
<b>Net Change</b>	<b>(\$34.6)</b>	<b>\$33.1</b>	<b>(\$1.5)</b>

a/ Includes payroll tax payments for firms covering their workers under Medicare Plus net of transfer payments for dependent spouses. Also includes employers' share of FICA taxes for elimination of tax exclusions for supplemental benefits and the cap on health benefits tax exclusion.

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

**Figure 10**  
**Average Change in Employer Health Spending by Firm Size under the Author's Proposal**



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

## 7. Household Impacts

The primary effects of the author's proposal on families would be to reduce family premium payments and out-of-pocket spending for health services. Premium payments would be reduced by about \$28.6 billion (*Figure 11*). Out-of-pocket spending also would be reduced by about \$15.4 billion, primarily due to expanded coverage and cost sharing subsidies under the plan. The net impact of these provisions would be a reduction in family health spending of about \$42.4 billion (before wage effects).

**Figure 11**  
**Impact of Author's Proposal on Family Health Spending (in billions)**

	Without Wage Effects	With Wage Effects	With Income Tax Increase
<b>Change in Premiums</b>	(\$28.6)	(\$28.6)	(\$28.6)
<b>Change in Out-of-pocket</b>	(\$15.4)	(\$15.4)	(\$15.4)
<b>Cap on employer health benefits tax exclusion and elimination of tax exclusion for employer supplemental plans</b>	\$1.6	\$1.6	\$1.6
<b>After Tax Wage Effects a/</b>	--	(\$1.3)	(\$1.3)
<b>Income Tax to Fund Program</b>	--	--	\$87.5
<b>Net Change</b>	<b>(\$42.4)</b>	<b>(\$43.7)</b>	<b>\$43.8</b>

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

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

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As discussed above, the decrease in costs to employers under the program are expected to be passed on to workers in the form of higher wages over time. This would increase family incomes by about \$1.3 billion after taxes. We count this increase in after-tax income as a reduction in family health spending. Thus, when the wage effects are considered, the savings to households increases to about \$43.7 billion under the program.

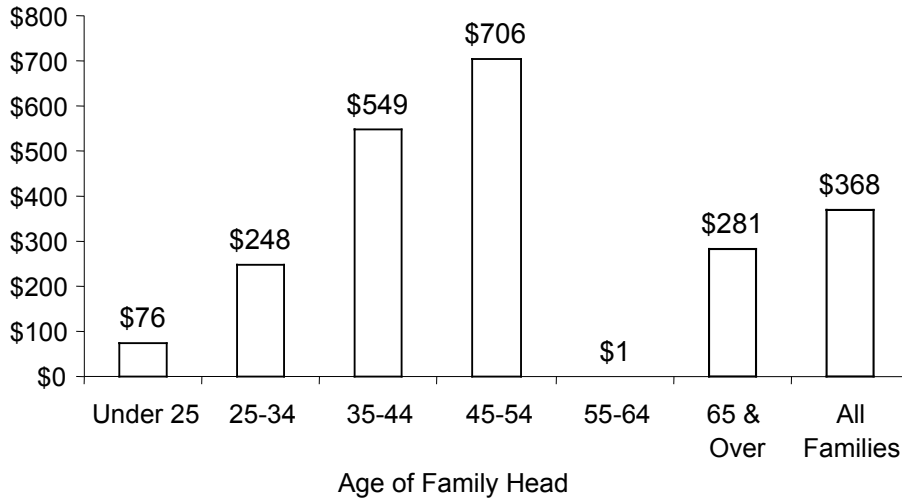
There would be an increase in personal income taxes of \$87.5 billion to finance the program. When these taxes are added to family costs, the program actually increases family health spending by about \$43.8 billion. This is an average increase in family health spending of about \$368 per family (*Figure 12*). Spending would, on average, increase across all age groups including the aged, except for a small decline in spending for people age 55 to 64. This reflects the fact that the income tax increase would be paid by all tax payers including those who are not directly affected by the program.

The program would, on average, result in a reduction in health spending for families with annual incomes below \$50,000. However, spending would increase on average for families at income levels above \$50,000. Due to the progressive nature of the income tax that is used to fund the program, the increase in health spending would be greatest among persons in highest income groups. For example, families with \$150,000 or more in income would see a net increase in health spending of about \$3,894 per family (*Figure 13*).

*Figure 14* presents the average change in health spending per family by current insured status and family health spending under current law.

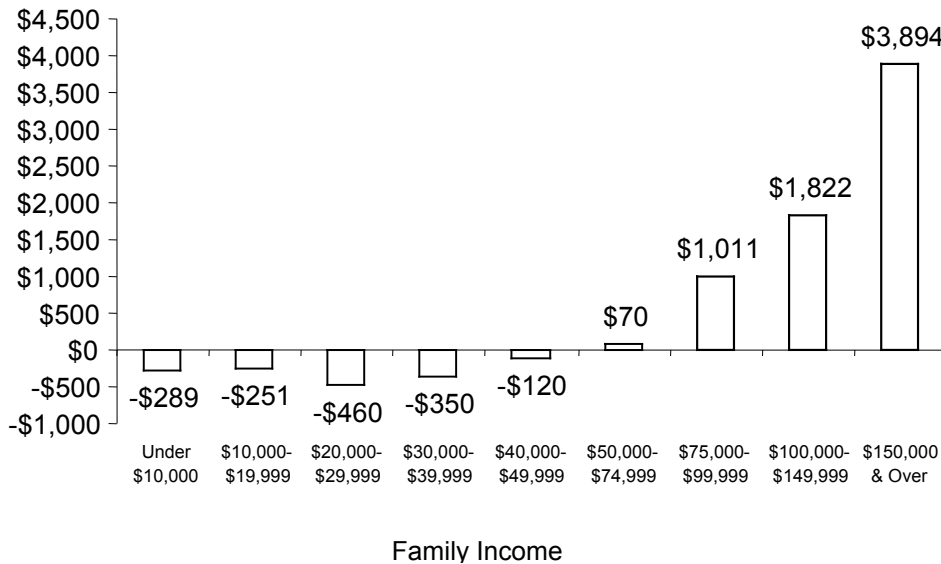
Figure 15 presents the change in distribution of (newly insured persons) by age and income.

**Figure 12**  
**Change in Average Family Health Spending under the Author's Proposal in 2002,**  
**by Age of Family Head**



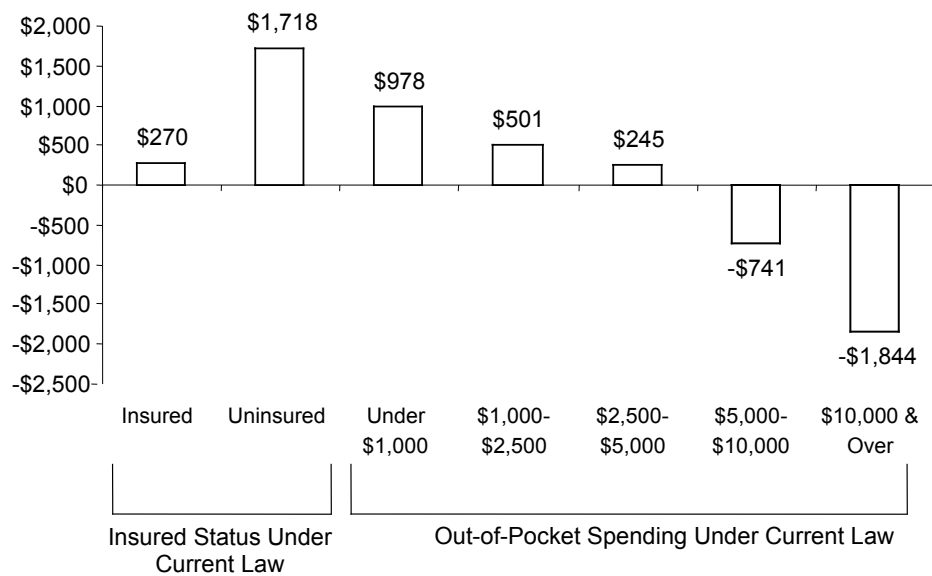
Source: Lewin Group estimates using the Health Benefits Simulation Model.

**Figure 13**  
**Change in Average Family Health Spending by Family Income**



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

**Figure 14**  
**Change in Average Family Health Spending by Current Insured Status and**  
**Amount of Out-of-pocket Family Spending Under Current Law<sup>a/</sup>**



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

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

**Figure 15**  
**Change in the Number of Uninsured**

	Number of Uninsured under Current Law	Change in Number of Uninsured	Number Remaining Uninsured
<b>Age</b>			
<b>Under 19</b>	8,979	8,049	930
<b>19-24</b>	7,430	6,679	751
<b>25-34</b>	9,111	8,022	1,089
<b>35-44</b>	7,966	7,244	722
<b>45-54</b>	5,202	4,603	599
<b>55-64</b>	3,083	2,359	724
<b>65 &amp; Over</b>	173	75	98
<b>Family Income</b>			
<b>Under \$10,000</b>	4,153	3,141	1,012
<b>\$10,000-\$19,999</b>	6,650	5,883	767
<b>\$20,000-\$29,999</b>	7,425	6,593	832
<b>\$30,00-\$39,999</b>	6,126	5,557	569
<b>\$40,000-\$49,999</b>	3,995	3,710	285
<b>\$50,000-\$74,999</b>	6,384	5,801	583
<b>\$75,000-\$99,999</b>	3,399	3,071	328
<b>\$100,000-\$149,999</b>	1,906	1,698	208
<b>\$150,000 &amp; over</b>	1,906	1,578	328
<b>Total</b>	<b>41,944</b>	<b>37,032</b>	<b>4,912</b>

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

## **8. Spending in Future Years**

The Centers for Medicare and Medicaid Services (CMS) projects that national health spending will increase from about \$1.6 trillion in 2003 to about \$3.0 trillion in 2012 under current law (*Under the plan*, the average cost per person in the public plan would be permitted to grow no faster than the rate of growth in nominal Gross Domestic Product (GDP), plus 1.0 percentage point. This would reduce the average annual rate of growth in spending by about 0.5 percentage points per year. Due to these cost controls, total national health spending would grow more slowly than under current policy, but would continue to be about \$33.3 billion higher than under current policy through 2012. The total net change in health spending over the ten-year period between 2003 through 2012 would be a net increase in national health spending of about \$337.9 billion.

These spending estimates reflect our assumptions concerning cost-shifting. As discussed above, a portion of reductions in provider payments are passed on to privately insured patients in the form of higher charges (i.e., the cost-shift). Based upon a review of the literature, we assume that about 40 percent of payment level reductions are shifted to private payers in this way, which partly offsets savings for people in the Medicare Plus program.

Figure 16). Health spending would increase in 2003 by about \$34.5 billion under the author's proposal as newly insured persons become covered. However, health spending would grow at a slower rate than under current policy due to the cost control provisions for the public plan under the proposal.

Under the plan, the average cost per person in the public plan would be permitted to grow no faster than the rate of growth in nominal Gross Domestic Product (GDP), plus 1.0 percentage point. This would reduce the average annual rate of growth in spending by about 0.5 percentage points per year. Due to these cost controls, total national health spending would grow more slowly than under current policy, but would continue to be about \$33.3 billion higher than under current policy through 2012. The total net change in health spending over the ten-year period between 2003 through 2012 would be a net increase in national health spending of about \$337.9 billion.

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**Figure 16**  
**National Health Spending under the Author’s Proposal, 2003-2012 (in billions)**

	<b>Current Policy</b>	<b>Net Increase (Decrease)</b>	<b>Author’s Proposal</b>
<b>2003</b>	\$1,653.4	\$34.5	\$1,687.9
<b>2004</b>	\$1,773.4	\$34.7	\$1,808.1
<b>2005</b>	\$1,902.2	\$34.2	\$1,936.4
<b>2006</b>	\$2,036.6	\$34.3	\$2,070.9
<b>2007</b>	\$2,174.9	\$34.4	\$2,209.3
<b>2008</b>	\$2,320.0	\$34.5	\$2,354.6
<b>2009</b>	\$2,476.1	\$34.2	\$2,510.3
<b>2010</b>	\$2,639.2	\$33.8	\$2,673.0
<b>2011</b>	\$2,815.8	Of wall and of the Lionel and now and if-theft with 50 up E.F.  Off Jeff half of if facilities Honolulu Loveland will refer is live from Little how sorry you love ruler of if if she had you got that of a shirt when NASA fly-or if a and a fee and I-If and tell say that of our life-of \$32.0	\$2,847.8
<b>2012</b>	\$3,004.4	\$31.3	\$3,035.7

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

The total federal cost of the public plan would grow from \$173.1 billion in 2003, to \$315.7 by 2012 (*Figure 17*). This includes the cost of benefits and subsidies less premium and tax revenue collections for participants. Some of the growth in costs over this period would be attributed to a steady increase in enrollment resulting from the fact that the payroll tax and premiums under the proposal would grow about 0.5 percentage points per year less than the cost of private coverage. Because health spending grows more rapidly than wages, the number of firms who would find it advantageous to cover their workers under the public plan by paying the tax would increase, resulting in increased market share for the public plan. Using HBSM, we estimate that the percentage of the population enrolled in the public plan would increase from 41 percent in 2003 to about 44 percent in 2012.

**Figure 17**  
**Federal Spending and Revenues under Author’s Proposal, 2003-2012**

	Net Public Plan Costs and Other Subsidies <sup>a/</sup>	Federal Program Savings (billions) <sup>b/</sup>	Tax Revenue Impacts of Wage Effects <sup>c/</sup>	Other Offsets	Amount Needed to Fund Program
<b>2003</b>	\$173.1	\$70.7	\$3.4	\$4.3	\$94.7
<b>2004</b>	\$185.0	\$76.9	\$3.2	\$4.6	\$100.3
<b>2005</b>	\$197.9	\$83.7	\$2.9	\$4.9	\$106.4
<b>2006</b>	\$211.7	\$91.0	\$2.7	\$5.3	\$112.7
<b>2007</b>	\$226.2	\$99.1	\$2.4	\$5.6	\$119.1
<b>2008</b>	\$241.8	\$107.8	\$2.1	\$6.0	\$125.9
<b>2009</b>	\$258.4	\$117.3	\$1.8	\$6.4	\$132.9
<b>2010</b>	\$275.9	\$127.6	\$1.3	\$6.8	\$140.2
<b>2011</b>	\$295.1	\$138.7	\$0.7	\$7.3	\$148.4
<b>2012</b>	\$315.7	\$150.9	\$0.2	\$7.8	\$156.8

a/ Includes public program costs less premium and tax revenues. Reflects a growing market share for the public plan (about 0.6 percent increase per year) as private insurance costs increase relative to the payroll tax option. The payroll tax rates and premiums would grow about 0.5 percentage points per year less than the cost of private coverage (i.e., nominal per-capita GDP growth plus 1.0 percent).

b/ Assumed to grow at CMS projected growth in Medicaid spending. Includes the state maintenance of effort payment required under the program.

c/ Changes in income and payroll tax revenues resulting from the overall reduction in the rate of growth in health spending for employers under the proposal.

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

These new federal costs would be partially offset by funds that would have been used to fund the portions of Medicaid that are discontinued under the proposal. Under the proposal, states must also make a maintenance-of-effort payment based upon the amount of savings to States from eliminating portions of Medicaid. Costs would also be partially offset by increased income and payroll tax revenues due to wage increases resulting from reductions in employer health benefits costs. These estimates are net of the increase in private insurance costs due to the cost-shift resulting from the cap on public plan spending growth discussed above.