
Designing Health Insurance Market Constructs For Shared Responsibility: Insights From California

California's experience tested the potential of balancing responsibility among insurers, consumers, and the state and federal governments.

by Rick Curtis and Ed Neuschler

ABSTRACT: Moving toward universal participation in health insurance using a "shared responsibility" approach requires new, more accessible, and more efficient ways for people who are not offered employer coverage to obtain coverage. California's recent health reform plan—which failed to pass—incorporated individual market reform and choice-pool constructs to achieve critically important risk spreading, assure solvency, and reduce cost shifts. These measures, as well as the considerations that led to their design, offer important insights for health reform at the federal level. [*Health Affairs* 28, no. 3 (2009): w431-w445 (published online 24 March 2009; 10.1377/hlthaff.28.3.w431)]

CALIFORNIA'S RECENT SHARED-RESPONSIBILITY PLAN for health reform incorporated coverage constructs intended to solve problems that need to be addressed by future health reform plans. Critical to reforms that can bring uninsured people into coverage is the development of more efficient and fair health insurance venues, especially for those not eligible for employer coverage. Massachusetts addressed these issues in 2006; however, like most states, California had a very different context than Massachusetts, including an aggressively underwritten individual market and more uninsured workers.

California's shared-responsibility approach to coverage included the following basic components: (1) individuals' responsibility to obtain health coverage; (2) employers' responsibilities to make meaningful payments toward health coverage costs, either directly or by paying a percentage-of-payroll fee to the state, and to make Section 125 tax sheltering available for workers' premium payments; (3) government's responsibility to ensure affordable coverage by subsidizing coverage for low-income residents and by providing ready access to coverage through mar-

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ket reforms and via a state choice pool.

California's final compromise bill, backed by Republican Gov. Arnold Schwarzenegger and Assembly Speaker Fabian Núñez, passed the Assembly in December 2007. In January 2008 the bill failed in the Senate Health Committee for a variety of fiscal and political reasons. But those reasons were largely unrelated to the market reforms discussed in this paper. A companion paper assesses how California balanced personal affordability, state costs, and employer responsibilities and also elaborates on the reasons why the bill failed to reach final adoption.¹

Specific topics addressed here include individual-market-reform issues, which populations were eligible to enroll in the pool, risk-selection issues and related considerations for designing the employer-pay requirement, and what role the pool was expected to play for lower- and higher-income populations. How to avoid shifting costs to employer plans is one consideration under the last topic.

The basic design and other considerations for the employer-pay requirement—a percentage of payroll—are presented in the companion paper. This paper discusses a key part of the rationale for choosing that basic design: a desire to avoid adverse selection—a fatal flaw of many earlier “pay-or-play” proposals.

The various components of the proposal interact in ways that affect its overall workability. Assessing those interactive effects is a key aspect of our analysis. Where helpful to explain what options were considered and why, we note important differing perspectives among policymakers and relevant interest groups. (Discussions of economic, procedural, and political reasons why the overall package was not ultimately enacted can be found in journalistic accounts.)

Our insights here derive from our role in providing technical assistance and analysis to senior California health officials during the development and consideration of the 2007 proposals. Although the final compromise plan passed only one chamber of the legislature, we believe that the final access provisions discussed here were well conceived to achieve their purposes. Where people receive coverage would differ under the competing proposals, particularly with respect to the size of the nongroup market and the new choice pool (Exhibit 1).

Individual Market Context And Reforms

The governor and the legislative leadership agreed that if people are to be required to have coverage, they must be able to purchase it readily (that is, “guaranteed issue”) and should not be charged more because of health status. With virtually everyone required to participate—including low-risk people—per capita health claims costs should reflect a normal distribution of risk. Although administrative costs for serving individuals are unavoidably higher than for serving groups, the state's leaders further agreed that current charges were unnecessarily high and adopted the governor's proposed 85 percent minimum loss ratio, which would limit administrative costs and profits to 15 percent of total premium.²

■ **Current market context.** California faced more difficult challenges to individ-

EXHIBIT 1
Estimated Coverage Status In California Before And After Reform Under Alternative Proposals, Millions Of People, 2007

Population under age 65	Before reform	After reform under		
		Governor's initial proposal ^a	Legislative proposal (AB 8) ^a	Final compromise (ABX1 1) ^b
Nongroup	2.0	2.5	1.4	1.6
New "choice pool"	- ^c	1.5	2.7	2.5
Uninsured	5.1	1.1	3.0	1.5
Medi-Cal/Healthy Families	5.9	7.3	5.9	7.3
Employer provided	18.8	19.4	18.8	18.9
Total	31.8	31.8	31.8	31.8

SOURCES: See below.

NOTES: Although the estimation model is built on data from the Census Bureau's Current Population Survey, population totals by insurance status and income are controlled to the 2005 California Health Interview Survey. People who are age sixty-five or older, are under age sixty-five but covered by Medicare, or have military health coverage are excluded from the data entirely, because they would not be affected by the proposal. The "uninsured" count includes some people who have coverage through county-sponsored programs. Details might not sum to totals because of rounding. Healthy Families is the state's State Children's Health Insurance Program (SCHIP).

^a Unpublished estimates by Jonathan Gruber. These estimates differ from previously released estimates because of adjustments to the estimation model made subsequent to the release of those estimates. Those adjustments make the estimates for the earlier proposals comparable to the estimates for ABX1 1.

^b J. Gruber, "Population Movement Estimates for Health Care Reform under ABX1-1 with the Voter Initiative Filed December 28, 2007," 11 January 2008, <http://www.calhealthreform.org/pdf/GruberAnalysis011108.pdf> (accessed 10 June 2008).

^c Zero.

ual market reform than Massachusetts did (Exhibit 2). In California's current individual insurance market, health underwriting is permitted and is practiced aggressively. Further, some individual insurance plans can be offered that exclude expensive service categories such as maternity benefits. As a result, individual-market premiums in California are often quite low for people healthy enough to qualify (especially for certain people, such as younger males); people with existing health conditions are often denied coverage and can go only to the high-risk pool, although many cannot afford its premiums.

California has a relatively large individual health insurance market. At any given time, about two million nonelderly Californians have individual coverage—about 55 percent as many as have small-group coverage, compared to under 10 percent in Massachusetts before reform.³ Conversely, even prior to Massachusetts' 2006 reforms, health rating was prohibited, and coverage was available on a guaranteed basis. As it was a voluntary market (that is, no individual mandate), these rules resulted in very high individual insurance premiums as a result of adverse selection. Therefore, Massachusetts was able to greatly lower premiums for people with individual coverage by merging its individual market with its much larger small-group market and bringing in lower risks with an individual mandate.

■ **Individual-market reforms.** There was general agreement in California that

**EXHIBIT 2
Comparing Market Rules For The Individual (Nongroup) Insurance Markets In
Massachusetts And California**

Pre-reform environment	California	Massachusetts
Guaranteed issue?	No	Yes
Health rating (use of health status or medical condition allowed in setting premium rates)?	Yes	No
Limits on premium variation by age?	No	2:1
Size of individual market relative to small-group market (covered lives)	55% ^a	Less than 10% ^b
Reform provisions		
Individual and small-group markets merged?	No	Yes
Guaranteed issue?	Yes	Yes
Health rating (use of health status or medical condition allowed in setting premium rates)?	Phased out over four years (starting at $\pm 20\%$)	No
"Grandfather" existing (underwritten) policies?	Yes	N/A
Limits on premium variation by age?	Authorized, not specified	2:1
Benefit-plan "tier" structure and associated requirements?	Yes	For Connector-offered products only
Risk adjustment between plans and "backstop" reinsurance for market?	Yes	No

SOURCES: Authors' analysis; and see below.

^a California Health Benefits Review Program, "Table 1: Insurance Coverage of Californians, 2006," http://www.chbrp.org/documents/table1_2006_011207.pdf (accessed 31 July 2008).

^b Gorman Actuarial LLC, "Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets," 26 December 2006, http://www.mass.gov/Eoca/docs/doi/Legal_Hearings/NonGrp_SmallGrp/FinalReport_12_26.pdf (accessed 6 August 2008). The Census Bureau's Current Population Survey was not used for this comparison because its results for Massachusetts differ significantly from the state's own data.

an individual mandate made it necessary and feasible to guarantee access and eliminate health rating, but difficult transition issues had to be addressed. The governor and the legislative leadership wanted to avoid a rate shock that might cause a backlash against market reforms and the individual mandate. They therefore agreed to allow current individual insurance subscribers to keep their low, underwritten rates and existing policies, even where they did not meet the new minimum requirements. Although politically necessary, this "grandfathering" meant that initial enrollment in the new, reformed individual market would likely have a higher risk distribution and therefore face higher premiums than if the new enrollees were pooled with existing, healthier subscribers. For similar reasons, policymakers decided to phase in the elimination of health rating over four years.

The insurance industry was divided over the proposed system reforms. Some companies aggressively opposed them—notably, Blue Cross of California (a Well-

Point/Anthem subsidiary), the carrier with the largest individual-market enrollment. But other health plans were supportive of reforms. For example, nonprofit Blue Shield of California put forth a universal coverage plan involving an individual mandate and guaranteed issue as early as December 2002.⁴

A surprising impetus for major market restructuring came from an insurer coalition, led by California-based Kaiser Permanente, Blue Shield, and HealthNet, that developed proposals to address risk-selection problems that would occur with guaranteed individual access in an unstructured market. The coalition's reform construct was loosely patterned after the Medicare supplemental plan structure: all products sold to individuals (other than those "grandfathered") were to be grouped into five "coverage choice categories," or tiers, ranging from the lowest-cost/highest-deductible plan allowed under reforms to the most comprehensive benefit packages.

To preclude any carrier from offering only low-benefit products that would be attractive to low-risk people—and thereby creating solvency problems for competitors via risk selection—two rules were proposed. First, all carriers serving the individual market must offer plans in all five tiers. Second, the relative premium prices for different benefit plans had to be based on the relative actuarial values of those plans rather than on the risk profile of people who actually enrolled in each plan. Because of concerns over the risk profile of initial participants in the reformed market (for example, especially given the grandfathering of existing low-cost plans and enrollees), this coalition's initial proposal was that guaranteed issue pertain only to plans in the lowest-cost tier (or two lowest-cost tiers). But both the legislature and the governor believed that guaranteed access to all benefit tiers was essential where individuals are required to purchase coverage. Negotiations among the administration, legislature, and insurer coalition resulted in the following noteworthy measures.⁵

First, individuals were guaranteed initial access to any plan in any tier. People's ability to move between tiers would be limited to one tier per year (to limit risk-selection problems if people could jump from the lowest to the highest tier when their health needs changed). Second, risk-adjustment mechanisms would compensate for differential health risks assumed by individual health plans (to protect individual health plans that acted in good faith from potential adverse selection relative to competing plans). Third, state-funded reinsurance would be available if and only if the population in the reformed individual market turned out to be significantly (more than 10 percent) more costly, on average, than the population in the new state purchasing pool. This "backstop" reinsurance provision was designed as a fiscally prudent way for the state to address concerns that the reformed market's risk profile would be expensive if the state did not effectively enforce the individual mandate. Bringing low-risk uninsured people into coverage was especially critical, given that low-cost individual plans were grandfathered for insured individuals, taking them out of the reformed market's risk pool. To

avoid unnecessary reinsurance costs, the state would need to assure that low-risk individuals actually participated in coverage. If the state succeeded, the risk profile in the individual market was expected to be normal, and the “backstop” reinsurance approach would cost the state little or nothing. Thus, this reinsurance approach has very different cost implications from proposals that would have government pay most costs of all cases that exceed a certain dollar threshold.

In combination, these provisions would help assure that health insurance premiums in the individual market reflected costs for a normal, rather than high-risk, population and avoid an imbalance in the health care cost profile relative to the new purchasing pool. With these provisions and the pool design features discussed next, higher-income insured individuals were generally expected to stay in the individual market, while many low- and modest-income individuals would obtain subsidized coverage in the pool (Exhibit 3).

The ‘Pool’ And Who It Would Serve

■ **Key differences between the governor and the legislature.** Both Governor Schwarzenegger and the legislative leadership proposed to establish a state-run purchasing pool, offering choice of competing health plans as a new coverage venue for certain populations; however, their proposals differed with respect to the populations to be served (Exhibit 4). Related design differences had critical implications for the pool’s risk of adverse selection.

In the governor’s proposal, the purchasing pool was to be the exclusive source for low-income adults above the federal poverty level to get premium subsidies from the state; it would not be available to those not eligible for subsidies. (Adults under 100 percent of poverty and children under 300 percent of poverty were to be eligible for public programs.) People with incomes above the subsidy threshold who did not get coverage through their (or their spouse’s) employer would be required to obtain coverage outside the pool in the reformed individual market. This restriction was intended to both target use of available revenues on low-income subsidies and avoid incentives for employers with higher wage profiles to drop their group plans. That is, higher-wage employers could not “buy” pool coverage for their higher-wage workers by dropping their regular plan and paying the payroll fee instead.

The legislative leadership started with somewhat different perspective. Under the initial legislative proposals, all workers of employers choosing to pay the payroll fee would be automatically enrolled in the pool (or in Medi-Cal, if their income was below the poverty level). If not eligible for low-income subsidies, they would still have part of their premium paid out of payroll-fee revenue (“premium credit”). (This would reduce the proportion of payroll-fee revenues available to subsidize lower-income groups. Under the governor’s proposals, the payroll fees would be used to help pay for all subsidized low-income populations, regardless of their employment status.)

EXHIBIT 3
Changes In Nongroup Enrollment And Pool Enrollment In California, By Prior Coverage Source And By Income, Millions Of People, 2007

	Family income as percent of federal poverty level			
	All Incomes	<25% (receive subsidies in pool)	250%–400% (tax credits only in pool)	>400% (no subsidies or credits)
Population under age 65				
Total nongroup enrollment before reform	2.0	0.5	0.4	1.1
Movement (to)/from				
New pool	(0.5)	(0.2)	(0.2)	(0.1)
Uninsured	0.3	0.0	0.1	0.2
Employer-provided	(0.0)	(0.0)	(0.0)	(0.0)
Medi-Cal/Healthy Families	(0.1)	(0.1)	(0.0)	– ^a
Total nongroup enrollment after reform	1.6	0.2	0.2	1.2
Total enrollment in new pool	2.5	1.7	0.6	0.2
Prior coverage source of pool enrollees				
Nongroup coverage	0.5	0.2	0.2	0.1
Uninsured	1.4	0.9	0.3	0.1
Employer-provided	0.4	0.4	0.0	0.0
Medi-Cal/Healthy Families	0.2	0.2	0.0	0.0

SOURCES: J. Gruber, "Population Movement Estimates for Health Care Reform under ABx1-1 with the Voter Initiative Filed December 28, 2007," 11 January 2008, <http://www.calhealthreform.org/pdf/GruberAnalysis011108.pdf> (accessed 10 June 2008); and unpublished estimates.

NOTES: Although the estimation model is built on data from the Census Bureau's Current Population Survey, population totals by insurance status and income are controlled to the 2005 California Health Interview Survey. People who are age sixty-five or older, are under age sixty-five but covered by Medicare, or have military health coverage are excluded from the data entirely, because they would not be affected by the proposal. The "uninsured" count includes some people who have coverage through county-sponsored programs. Details might not sum to totals because of rounding.

^aZero. 0.0 denotes less than 0.05 (50,000).

A key reason for the legislative design was to make the payroll assessment qualify as a "fee," which requires only a majority vote (because all—and only—fee-paying employers' workers benefit), rather than a "tax," which requires a politically unattainable two-thirds vote in each legislative chamber for enactment.⁶ (Republicans uniformly opposed to any tax increase held more than one-third of each chamber's seats.) But the legislative leadership's design also reflected labor groups' view of the pool as an alternative vehicle for coverage of whole employer groups, rather than primarily for uninsured individuals. Labor pressed for higher employer fee levels and substantial pool "contributions" toward higher-income (as well as lower-income) workers' premiums.⁷

Covering all "pay" employer workers in the pool would also improve their continuity of coverage as their family income (and subsidy eligibility status) changed. And it could simplify roles for these employers, which would otherwise have to deal with the pool for their low-income workers' premium contributions, and so forth, and with other sources for higher-income workers.⁸

For wage-and-salary workers, a choice pool (or exchange) can attain the administrative efficiencies of employment-based plan enrollment, payment via pay-

EXHIBIT 4
Populations Served (Exclusively) By New California Pool Under Alternative Proposals

Income as percent of federal poverty level	Type of employment		Workers ineligible for coverage offered by "play" employers
	Self-employed and nonemployed	Workers at "pay" (nonoffering) employers	
Governor's initial proposal			
100-250%	Yes ^a	Yes ^a	Yes ^a
>250%	No	No	No
Legislative leadership's proposal			
100-300%	Parents only ^b	Yes	Parents only ^b
>300%	No	Yes	No
Final compromise			
100-250%	Yes ^a	Yes	Yes ^a
250-400%	Tax-credit recipients only	Yes	Tax-credit recipients only
>400%	No	Yes	No ^c

SOURCE: Authors' analysis of California proposals.

^aLow-income people were not required to purchase coverage through the pool, but they could receive subsidies only through the pool.

^bIn the legislative leadership's proposals, parents under 300 percent of poverty could access coverage through the pool regardless of their work status (and it was assumed that federal Medicaid matching funds would be available for them).

^cIneligible workers at offering employers could come to the pool only if the employer elected to make the pool the exclusive offering under its Section 125 plan for ineligible workers.

roll withholding, and single point of payment for employers. It thus can lower costs compared to individual-market coverage, while providing workers with a choice of competing plans. For self-employed individuals not receiving subsidies or tax credits, however, a pool would not offer inherent administrative efficiencies over direct enrollment and billing by individual carriers.

■ **Adverse-selection issues.** California policymakers were acutely sensitive to adverse-selection risks as a result of the state's extensive experience with purchasing pools offering individual choice of health plans for modest-income and small-firm populations. In 2006, PacAdvantage, an employee-choice pool for small employers originally run by the state, failed as a result of adverse-selection problems.

Risk-spreading implications of California's employer fee and subsidy approach. A key reason California based "pay-or-play" employer fees on a percentage of payroll and concentrated the subsidies financed by those fees on low-income workers was to avoid adverse selection regarding which employer groups participated in the state pool.⁹ Under this construct, employers with low wage profiles would pay relatively low fees but have a high proportion of their workers eligible for subsidies. Such employers would be attracted to the pool, regardless of their workers' risk profile. Conversely, high-wage firms with few subsidy-eligible workers would not find the pool attractive, even if their workers were high-risk. (And, although em-

ployers would only choose to “pay” where their fees plus worker payments were less than their workers’ true coverage costs, federal matching funds available for low-income people could cover the shortfall where most workers are low wage.)

Employer “pay-or-play” approaches based on a flat dollar amount per worker or a percentage of premium, and that provide substantial premium subsidies to all workers of “pay” employers regardless of income, are subject to severe adverse selection. Analysis of earlier California legislation found that this would have been a fatal flaw.¹⁰ Employer groups that could provide comparable or better direct coverage at less cost—because their workers were relatively young and healthy—would do so, leaving employer groups with more expensive age and health profiles to be served by the government-sponsored pool.

Adverse-selection risk from higher-wage employer groups. Although the legislature’s initial construct adopted a percentage-of-payroll employer fee, it did not concentrate subsidies on lower-income workers, as the governor’s proposal did. As a result, adverse selection would have been a major problem. The proposal guaranteed to pay a substantial share of premiums for all workers of employers that opted to pay the defined fee. Thus, the “pay” option would be especially attractive to an employer with a preponderance of older, less healthy workers, who would otherwise be paying very high costs for coverage. The opposite would be true for younger, healthier groups, whose coverage costs would be lower than their payments to the pool would be. Thus, the unsubsidized part of the “pay” pool would in effect be a high-risk pool, requiring a substantial source of outside revenues to remain solvent.¹¹ An estimate of a proposed 50 percent “premium credit” for higher-income workers in the pool indicated that this could increase the revenue shortfall—that is, pool and public coverage expansion costs less associated federal matching funds and employer and individual contributions—by \$1.3 billion, or 48 percent.¹²

Providing a substantial premium credit for all pool workers was touted by supporters as applying “social insurance principles” to this pay-or-play construct. But social insurance depends on broader risk spreading and shared costs, and it works only because everyone participates. If participation in the pool is optional, the risk spreading essential to social insurance is lost.¹³

In the final compromise package, the governor acquiesced to the legislature’s position that higher-income employees of “pay” employers should be included in the pool. But the premium credit for those workers was only 20 percent of the lowest-cost single-coverage plan offered through the pool (which was not specified in the legislation, but, by mutual agreement, estimates were based on a \$5,000 deductible plan). This much-reduced premium credit was acceptable to legislative constituencies only because sizable tax savings through Section 125 plans—available to all workers—together with the 20 percent credit would reduce these workers’ costs to around 50 percent of the premium.¹⁴ Adverse selection would be avoided because even high-risk employer groups with high wage profiles would not drop equally tax-advantaged coverage to instead pay payroll fees far exceeding

the small premium credit their workers would receive.

Minimizing pool exposure to individual selection. If individuals were allowed to choose between purchasing through the pool or through the regular individual market, and if (unlike Massachusetts) those venues offered different plans at different rates, there would be much risk that the outside market would find ways to attract healthy, low-cost individuals and refer less healthy, higher-cost people to the pool.

To minimize these risks, the parties generally agreed that premium subsidies and tax credits would be available only for coverage purchased through the pool and that unsubsidized people would not be permitted to choose, as individuals, between the pool and the regular individual market. Thus, other than “pay” employers’ workers, the only people over 250 percent of poverty allowed to be in the pool were (1) modest-income people receiving a targeted tax credit, and (2) workers ineligible for their offering employer’s plan, where the employer designated the pool as the vehicle for Section 125 plan coverage for all such workers.¹⁵ In addition, where unsubsidized, higher-income workers participated in the pool through their employer, the pool would use the same premium-rating factors (for example, age) used in the regular individual market (Exhibit 3).

Different Pool Roles And Payment Rates By Income Group

Another important coverage-construct dimension is what purchasing role a health insurance “pool” or “exchange” will play, and for whom. Related dimensions include relative premium levels and underlying provider payment rates.

The terms “exchange” and “purchasing pool” connote different market roles. In its purest form, an exchange would be a clearinghouse for all health insurance plans available in the individual or employer market. It would provide objective consumer information and would be a convenient venue for employers to offer their workers a choice of competing plans; however, plans would set their own prices as they competed for enrollment of individuals. A pure purchasing pool, on the other hand, would aggressively negotiate and selectively contract to obtain the best possible health insurance value (as legislative constituencies advocated). But just as the often referenced Federal Employees Health Benefits (FEHB) program varies greatly from a pure exchange model (as does the Massachusetts Connector), so, too, do the proposals and final plans in California vary from a pure purchasing pool.

Policymakers’ perspectives and goals regarding payment roles and rates are often different with respect to “on-budget” government-subsidized populations than for privately financed populations. Such distinctions were reflected in the California proposals, in some respects paralleling Massachusetts’ arrangements.

■ **Lower-income subsidized population.** For the low-income subsidized population, California policymakers agreed that a purchasing pool should have the authority to negotiate and selectively contract with plans—as the Healthy Families

(California's State Children's Health Insurance Program, or SCHIP) program now does for children's coverage. It was consistently assumed that enrollees would have a choice among participating health plans—private plans as well as locally sponsored public plans (which participate now in public programs). But there were continuing differences over what premium and provider payment levels the state could afford and what would work in terms of providers' participation and access for recipients. Related were concerns over provider cost-shift effects on commercial-market plans and purchasers.

A basic tenet of the governor's plan was to reduce the "hidden tax," or cost shift, that providers add to the bills of insured patients (to make up for uncompensated care provided to uninsured patients and for below-cost reimbursement by public programs). His proposal assumed Medicare provider payment rates for the lower-income subsidized population in the pool—a compromise between commercial rates and Medi-Cal rates that derived from one option under a plan put forth by Kaiser Permanente chief executive officer George Halvorson and colleagues.¹⁶ Both the governor's proposal and the final compromise also dramatically increased Medi-Cal provider payment rates.¹⁷ The final bill assumed provider payment rates somewhat lower than Medicare (but above Medi-Cal) rates for this lower-income adult population, based on rates used in Healthy Families for children in the same income range (100–250 percent of poverty), which are estimated to be approximately 85 percent of Medicare rates.¹⁸

These rate levels appeared achievable because many providers are available through Healthy Families–participating health plans and because most estimated lower-income pool enrollees were previously uninsured. These rates would greatly reduce uncompensated care costs and associated cost shifts, and they should exceed the direct (marginal) costs of providing care for this newly insured population. So hospitals should prefer them over providing uncompensated care. However, a Legislative Analyst's report noted that if per capita costs were 20 percent higher than the sponsors assumed, program costs would exceed expected revenues by almost \$1.5 billion in the fifth year of operation.¹⁹ Senate Health Committee members voting against the final bill noted the uncertainties regarding attainable rates.

■ **Higher-income population.** The pool's role for higher-income (nonsubsidized) workers was a more complex issue than its role for low-income workers. In the governor's original proposal, no higher-income (nonsubsidized) people were eligible for the pool. The legislative leadership's proposals, which consistently included all "pay" employers' workers and dependents in the pool, regardless of income, did not expressly distinguish the pool's purchasing role by income or subsidy status. This lack of clarity reflected differences among groups generally supportive of the overall reform package. Some wanted Medi-Cal plans for lower-income groups only. Others advocated for a very aggressive purchasing role and for offering the same health plans (with discounted provider payments) across all income groups.

A pragmatic state budgetary concern was that providers would be unlikely to accept discounted rates for state-subsidized populations if the same plans paying the same rates also enrolled higher-income workers who otherwise would have private market coverage. Further, insurers and the administration were concerned that if the discounted rates were below providers' average costs, the resulting cost shifts to the employer-group market could be unsustainable.

Given that Medicare payments are reportedly below average provider cost levels in many areas, similar concerns will doubtless manifest themselves as federal policymakers consider offering Medicare, or plans paying Medicare rates, as an alternative coverage source for various populations under federal reform.²⁰

■ **Similarities and differences from Massachusetts.** The final compromise bill effectively established separate pools with separate rates for lower-income subsidized versus higher-income participants. It specified that the pool would offer Healthy Families plans only to low-income populations. Higher-income populations in the pool would be offered commercial plans in each of three specified benefit tiers (that is, three of the five individual-market reform tiers discussed earlier.) Here the final California bill was similar to the Massachusetts construct, under which the Connector operates two programs: Commonwealth Care makes lower-cost Medicaid-participating provider networks available to subsidized populations, while Commonwealth Choice offers commercial plans to nonsubsidized populations (Exhibit 5).²¹

There were also key differences: the California pool would have the authority to negotiate better rates than the outside market for its higher-income populations, while the plans negotiated by Commonwealth Choice are also available at the same premiums in the regular market. Under the California plan, higher- and moderate-income enrollees were primarily "pay" employers' workers, dependents, and tax-credit recipients exclusively served through the pool. Health plans could only reach these groups by gaining a contract with the pool, which could obtain lower prices without undercutting a given carrier's regular market business. In contrast, the Massachusetts Connector competes against the regular market for enrollment of higher-income individuals and of small employers. In such a context, health plans would be loath to offer a lower price through the Connector, because it would draw enrollment away from their direct-contract market.²²

Insights For Federal Reform

Like current federal proposals, the California shared-responsibility plan sought to bring the uninsured into coverage through a reformed system involving choice of health plans. California's framework sought to create appropriate rules and constructive incentives for insurers, individuals, and employer groups. It included noteworthy approaches to encourage competition based on efficiency rather than risk selection.

The plan's individual-market-reform construct has meritorious features for

EXHIBIT 5
Comparing The Roles Of The Pool/Connector In California And Massachusetts, By
Income Level

	California	Massachusetts
Low-income population	<250% of poverty	<300% of poverty
Type of plans made available?	Managed care organizations, including Healthy Families (SCHIP)-participating county health plans	Medicaid-participating managed care organizations
Moderate- and higher-income population	>250% of poverty	>300% of poverty
Can individuals choose between the pool and the "outside" nongroup insurance market?	No (except those eligible for tax credits could forgo credit and buy outside)	Yes (Connector plans also available in outside market at same price)
Populations covered exclusively through the pool	Several (see Exhibit 3)	None (except young adults may choose low-cost product offered only through the Connector)
Can the pool negotiate rates different from those available in the nongroup market?	Yes	No (except low-cost product for young adults offered only by Connector)

SOURCE: Authors' analysis of California and Massachusetts reforms.

NOTE: SCHIP is State Children's Health Insurance Program.

consideration in federal-level reform plans, whether as reforms for the conventional direct individual market, for insurance exchange(s) that replace that market, or across the market where both venues are proposed. In California, supporters viewed the structure as critical to insurers' ability to comply, in a competitive market, with the policy intent that higher-risk people have the same ready access to coverage at the same price as their low-risk peers. Opportunities for competitors to selectively market and enroll low-risk people were greatly reduced by stipulating five benefit tiers and requiring all competitors to offer plans in all five.

This structure complemented the reform plan's use of risk adjustment across competitors to minimize the relative advantage an insurer would gain from avoiding higher-risk populations. But given California's unusually large existing individual market enrollment, the indefinite grandfathering of preferred rates and substandard plans for existing enrollees raised serious concerns regarding risk-profile effects on the newly reformed individual market.

Publicly financed "backstop reinsurance" against marketwide adverse selection was designed to assure that insurers could guarantee issue to an unknown population without fearing and pricing for high-cost-profile enrollment. This also gave the state strong incentives to fulfill its promised role of bringing low- as well as high-risk uninsured people into coverage, because this would heavily affect whether the state would incur reinsurance costs, and what those costs would be.

A federal plan could use such an approach and avoid the high costs associated with proposals for broad-scale reinsurance of all expensive cases. Similarly, where federal plans propose exchanges along with direct markets, potential high costs of adverse selection could be avoided through careful design, as in California or Massachusetts. California's purchasing pool was to negotiate premiums as the exclusive venue for low-income subsidies and tax credits and for all workers of nonoffering employers (whose fee schedule was also designed to avoid selection effects). Alternatively, in Massachusetts, for nonsubsidized populations who are free to choose the direct market, the Connector offers products available at the same prices in the individual market.

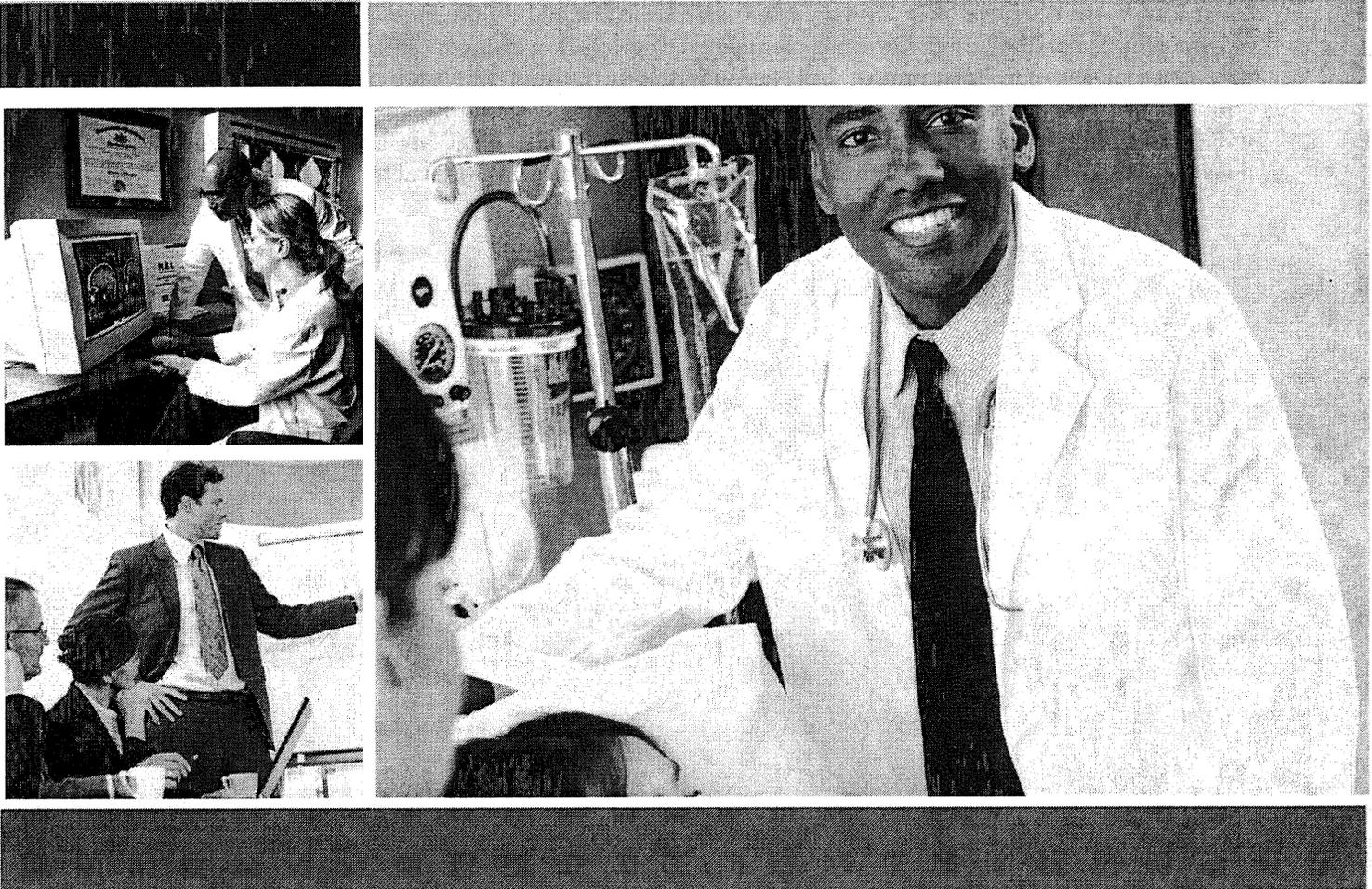
Choice is a strongly held American value and can be an important force for improved cost discipline. With respect to health insurance, however, unfettered individual choice across different coverage venues and benefit plans can cause severe cost shifting and adverse selection, which can greatly undermine the basic access and affordability goals of reform. California sought to avoid these problems by combining promising individual-market reforms and associated risk-spreading measures with careful design of a pool offering choice of plans. Within a framework of shared responsibility, such measures should help achieve sorely needed access and cost discipline in the U.S. health system.

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Preparation of this paper, and the multiyear technical-assistance project on which the authors' insights are based, was supported by the California HealthCare Foundation. The authors led an interdisciplinary project team that included Massachusetts Institute of Technology economist Jonathan Gruber, who provided cost and population-profile estimates with actuarial analysis from Jim Mays and Cathi Callahan (Actuarial Research Corporation), Susan Marquis (RAND, retired), and independent consultants John Grgurina, Cecil Bykerk, and Patricia Butler. They were fortunate to work with highly capable professionals dedicated to understanding the probable implications of alternative measures and to developing workable and sustainable policies. Those who were most involved in these market-construct issues included California Legislative leadership health staff Sumi Sousa, Scott Bain, and David Panush; Executive Branch officials Kim Belshé, Sandra Shewry, Cindy Ehnes, Lesley Cummings, Richard Figueroa, and Ana Matosantos; and senior health plan executives Jerry Fleming, Kaiser Permanente, Jay Gellert, HealthNet, and Ed Cymerys, Blue Shield of California. Sumi Sousa, Lesley Cummings, Michael Johnson, Elliot Wicks, Bob DiPrete, and Craig Van Sandt provided helpful review and comments.

NOTES

1. R.E. Curtis and E. Neuschler, "Affording Shared Responsibility for Universal Coverage: Insights from California," *Health Affairs* 28, no. 3 (2009): w417-w430 (published online 24 March 2009; 10.1377/hlthaff.28.3.w417).
2. In final form, this standard pertained to the average across all of an insurer's full-service plans in California.
3. California Health Benefits Review Program, "Table 1: Insurance Coverage of Californians, 2006," http://www.chbrp.org/documents/table1_2006_011207.pdf (accessed 31 July 2008); and Gorman Actuarial LLC, "Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets," 26 December 2006, http://www.mass.gov/Eoca/docs/doi/Legal_Hearings/NonGrp_SmallGrp/FinalReport_12_26.pdf (accessed 6 August 2008).
4. B.G. Bodaken, "Where Does the Industry Stand on Health Reform Today?" *Health Affairs* 27, no. 3 (2008): 667-674. See also Blue Shield of California, "Blue Shield's Proposal," <https://www.blueshieldca.com/bsc/covexpmission/bsproposal.jhtml> (accessed 5 August 2008).

5. References to the “final compromise” are based on the text of Assembly Bill No. 1 in the 2007–08 First Extraordinary Session (ABX1 1) of the California Legislature, as amended in the Senate, 16 January 2008, http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab_0001-0050/abx1_1_bill_20080116_amended_sen_v95.pdf (accessed 6 June 2008).
6. To avoid the two-thirds vote requirement, the governor and speaker ultimately separated the revenue provisions from the final bill and incorporated them into a proposed ballot initiative.
7. California unions strongly supported the previous employer play-or-pay legislation, SB 2, which was enacted in 2003 but repealed by public referendum in 2004. SB 2 specified much higher percentage-of-premium employer fees, particularly for low-wage groups.
8. The legislation required employers to establish plans under Section 125 of the Internal Revenue Code, so that their workers could pay premiums using pretax dollars.
9. See Curtis and Neuschler, “Affording Shared Responsibility.”
10. Institute for Health Policy Solutions, “Challenges and Alternatives for Employer Pay-or-Play Program Design: An Implementation and Alternative Scenario Analysis of California’s Health Insurance Act of 2003 (SB 2),” March 2005, <http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=109629&subtopic=CL499&subsection=reports> (accessed 19 May 2008).
11. If “outside” revenues were unavailable, a pool with this design would need to adjust the employer fees for the risk/cost profile of higher-wage workers—an unorthodox role for government and a potential Employee Retirement Income Security Act (ERISA) problem. *Ibid.*, sections 3.4.2 and 3.6.1.
12. Unpublished estimate. The illustrative estimate assumed that the pool premium (for workers above the sliding-scale subsidy range) would equal the seventy-fifth percentile of premium costs for employer coverage. This was optimistic. If the pool increased employers’ fees to offset costs from initial adverse selection, it could set in motion an adverse-selection “death spiral.”
13. See IHPS, “All-Consumer Choice Exchange,” in *Covering California’s Uninsured: Three Practical Options*, October 2006, <http://www.chcf.org/documents/insurance/CoveringCaliforniasUninsuredFull%20Report.pdf> (accessed 28 May 2008). In 2006, some of the governor’s advisers expressed interest in this approach.
14. R. Curtis, “Summing Up the Special Session: Technical Observations and Design Issues for Health Care Reform in ABX1-1,” Slide no. 15, “Affordability Example 3,” from a briefing sponsored by the California HealthCare Foundation, Sacramento, California, 8 February 2008, <http://www.calhealthreform.org/pdf/IHPS-CHCF-ABX1-1designissuesFeb2008.pdf> (accessed 17 June 2008).
15. See Curtis and Neuschler, “Affording Shared Responsibility.” There was no basis for estimating how many employers would designate the pool as the vehicle for Section 125 plan coverage.
16. G.C. Halvorson, F.J. Crosson, and S. Zatzkin, “A Proposal to Cover the Uninsured in California,” *Health Affairs* 26, no. 1 (2007): w80–w91 (published online 12 December 2006; 10.1377/hlthaff.26.1.w80). This proposal also suggested a “health care sales tax” similar to the governor’s proposed provider fees.
17. Current Medi-Cal payment rates are far below both Medicare rates and hospital costs. California hospitals assert that their uncompensated care costs for Medi-Cal patients exceed those for the uninsured. The hospital rate increases were critical to hospital support for hospital fees as a financing source for reforms. The legislative leadership’s initial bills did not include Medi-Cal rate increases or hospital fee financing.
18. The Healthy Families program is administered by the same independent agency and board—the Managed Risk Medical Insurance Board (MRMIB)—that was to operate the pool under all proposals.
19. E.G. Hill, Legislative Analyst’s Office, “Analysis of Fiscal Issues Related to Health Care Reform,” 22 January 2008, http://www.lao.ca.gov/2008/hlth/health_reform/health_reform_012208.pdf (accessed 4 March 2009).
20. A. Dobson, J. DeVanzo, and N. Sen, “The Cost-Shift Payment ‘Hydraulic’: Foundation, History, and Implications,” *Health Affairs* 25, no. 1 (2006): 22–33; and MedPAC, *Report to the Congress: Variation and Innovation in Medicare*, 12 June 2003, http://www.medpac.gov/documents/June03_Entire_Report.pdf (accessed 5 June 2008).
21. See the Connector Authority home page, <http://www.mahealthconnector.org>.
22. For a fuller discussion of these dynamics, see “What Health Insurance Pools Can and Can’t Do,” Insurance Markets Issue Brief, November 2005, <http://www.chcf.org/documents/insurance/WhatHealthInsurancePoolsCanAndCantDo.pdf> (accessed 5 August 2008).



The Cost and Coverage Impacts of a Public Plan: Alternative Design Options

Staff Working Paper #4

Prepared by

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April 6, 2009

About The Lewin Group

The Lewin Group is a health care and human services policy research and management consulting firm. We have over 25 years of experience in estimating the impact of major health reform proposals. The Lewin Group is committed to providing independent, objective and non-partisan analyses of policy options. In keeping with our tradition of objectivity, The Lewin Group is not an advocate for or against any legislation. The Lewin Group is part of Ingenix, Inc., which is a wholly owned subsidiary of the UnitedHealth Group. To assure the independence of its work, The Lewin Group has editorial control over all of its work products.

Summary and Introduction

President Obama has proposed to create a “public plan” that would compete for enrollment with the private insurance industry, but has provided few details on how it would work. During the 2008 campaign, Senators Clinton and Edwards proposed a public plan administered through Medicare using Medicare provider reimbursement levels. Employers and individuals would have been able to purchase coverage from the public plan by paying a full cost premium, with subsidies provided for low-income families.

The public plan is difficult to evaluate because no one has specified in legislation how it would work. During the presidential campaign the President did not specify that the plan would be modeled on Medicare, and said that the plan would be open to only individuals, the self-employed and small firms. Senator Baucus has also proposed a public plan, but has not yet specified payment levels or the groups that would be eligible to enroll.

Consequently, in this paper, we present impact estimates under several variations on the public plan model. Under each variation, we assume that the public plan is implemented together with President Obama’s coverage expansion proposals, which we estimate would cover about 28 million uninsured people.

If Medicare payment levels are used in the public plan, premiums would be up to 30 percent less than premiums for comparable private coverage. On average, the monthly premium in the public plan for a typical benefits package would be \$761 per family compared with an average of \$970 per family in the private market for the same coverage.

If as the President proposed, eligibility is limited to only small employers, individuals and the self-employed, public plan enrollment would reach 42.9 million people. The number of people with private coverage would fall by 32.0 million people. If private payer reimbursement levels are used by the public plan, enrollment would be lower, with only 10.4 million people switching to the public plan from private insurance.

If the public plan is opened to all employers as proposed by Senators Clinton and Edwards, at Medicare payment levels we estimate that about 131.2 million people would enroll in the public plan. The number of people with private health insurance would decline by 119.1 million people. This would be a two-thirds reduction in the number of people with private coverage (currently 170 million people). Here again, if the higher private payer levels are used, enrollment in private insurance would decline by only 12.5 million people.

Medicare premiums would be lower than private premiums because of the exceptional leverage Medicare has with providers. Medicare pays hospitals about 30 percent less than private insurers pay for the same service. Physician payments are about 20 percent less than under private coverage. Also, because Medicare has no allowance for insurer profits or broker/agent commissions, administrative costs for this population are about one-third of administrative costs in private health plans.

Assuming Medicare reimbursement rates and eligibility for all individuals and employers, provider net income would decline under this public plan proposal, even after accounting for reduced uncompensated care and increased utilization for the newly insured. Net hospital

revenues would fall by \$36 billion (4.6 percent), and physician net income would fall by \$33 billion (6.8 percent). If eligibility is restricted to individuals and small firms, net hospital revenues would actually increase by \$11.3 billion due to the increase in newly insured individuals. But net physician incomes would decline by \$3.0 billion.

Our estimates and methodology are presented in the following sections:

- Features of the public plan;
- Premiums in the public plan;
- Coverage effects;
- Provider impacts;
- Simulating effects for individuals; and
- Simulating effects for employers.

A. Structure of the Public Plan

For illustrative purpose, we begin the analysis by estimating the effect of creating a new public plan modeled on Medicare that is available to individuals and the self-employed. Also, all employers would be able to purchase coverage for their workers through the public plan. We assume that providers would be reimbursed using Medicare payment levels.

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

In addition, we assume that the public plan would be implemented as part of a health reform program that includes coverage expansions similar to those proposed by President Obama in the 2008 campaign. For illustrative purposes, we assume the following:¹

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

¹ "McCain and Obama Health Care Policies: Cost and Coverage Compared," The Lewin Group, October 8, 2008.

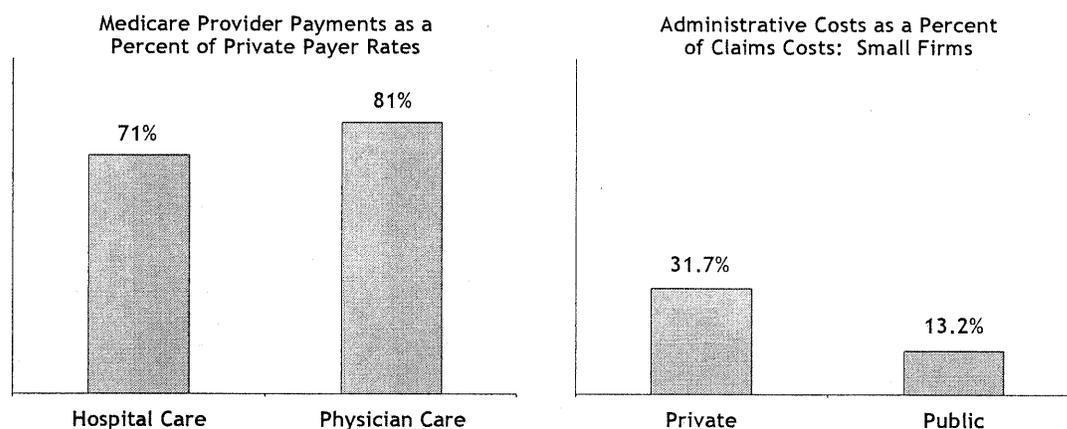
- Tax credits are provided to small employers (fewer than 10 workers) with low-wage workers for up to 50 percent of employer spending for worker coverage.

We used The Lewin Group Health Benefits Simulation Model (HBSM) to simulate the effect of such a program on coverage.²

B. Premiums in the Public Plan

We estimate that premiums for the public plan under this scenario would be between 30 percent and 40 percent less than premiums for comparable private coverage. As shown in *Figure 1*, provider payment levels for hospital services under Medicare are equal to only about 71 percent of what is paid by private health plans for the same services. In fact, Medicare payments to hospitals are actually equal to only between 92 percent and 95 percent of the cost of the services provided by hospitals.³ For physician services, Medicare pays only about 81 percent of what is paid by private health plans for the same services.⁴

Figure 1
Benefits and Administrative Costs Under a Medicare-based Public Plan and Private Insurance



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

Administrative costs are also expected to be lower for the public plan than under private insurance, reflecting that the public plan would not include an allowance for insurer profit and insurance agent and broker commissions and fees. Administrative costs, including profit and commissions, for privately insured small groups are on average equal to about 31.7 percent of covered benefits. If implemented through Medicare, administrative costs would be equal to about 13.2 percent of covered services.

² "The Health Benefits Simulation Model (HBSM): Methodology and Assumptions," The Lewin Group, February 19, 2009.

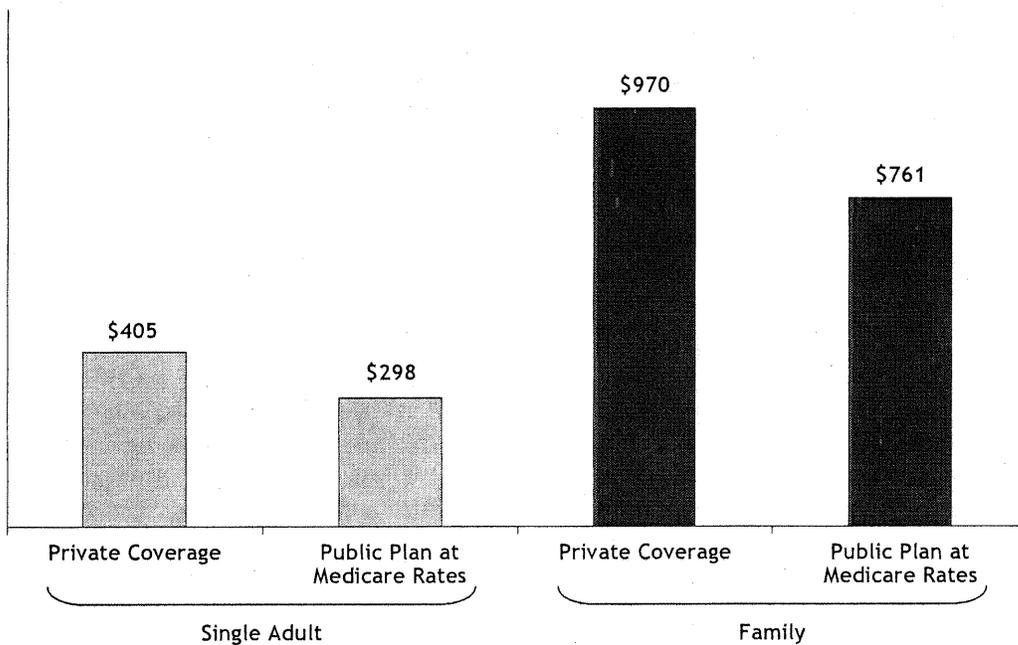
³ American Hospital Association, "Trends Affecting Hospitals and Health Systems," TrendWatch Chartbook, April 2008.

⁴ State Health Facts, The Kaiser Family Foundations (KFF), 2003 report.

Our estimate of administrative costs is based upon a detailed analysis of administrative costs under insurance pools which we present in our model documentation.⁵ These administrative costs are about twice what administrative costs currently are in the Medicare program (about 6.5 percent of benefits). Costs will be higher in the public plan than in Medicare because the program will need to process the movement of individuals across health plans when people decide to change their source of coverage. The plan will also need to collect premiums from individuals and employers who decide to enroll. These functions are not required for the current Medicare populations once enrolled.

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

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



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

C. Coverage Effects

We estimate that the Obama-like health reform program described above would reduce the number of uninsured by about 28 million people. If we assume that the public plan is open to all individuals, the self-employed and all firms, the public plan would enroll about 131.2 million people (includes some uninsured who become covered). The number of people with private health insurance would decline by about 119.1 million people (Figure 3). This is equal to about

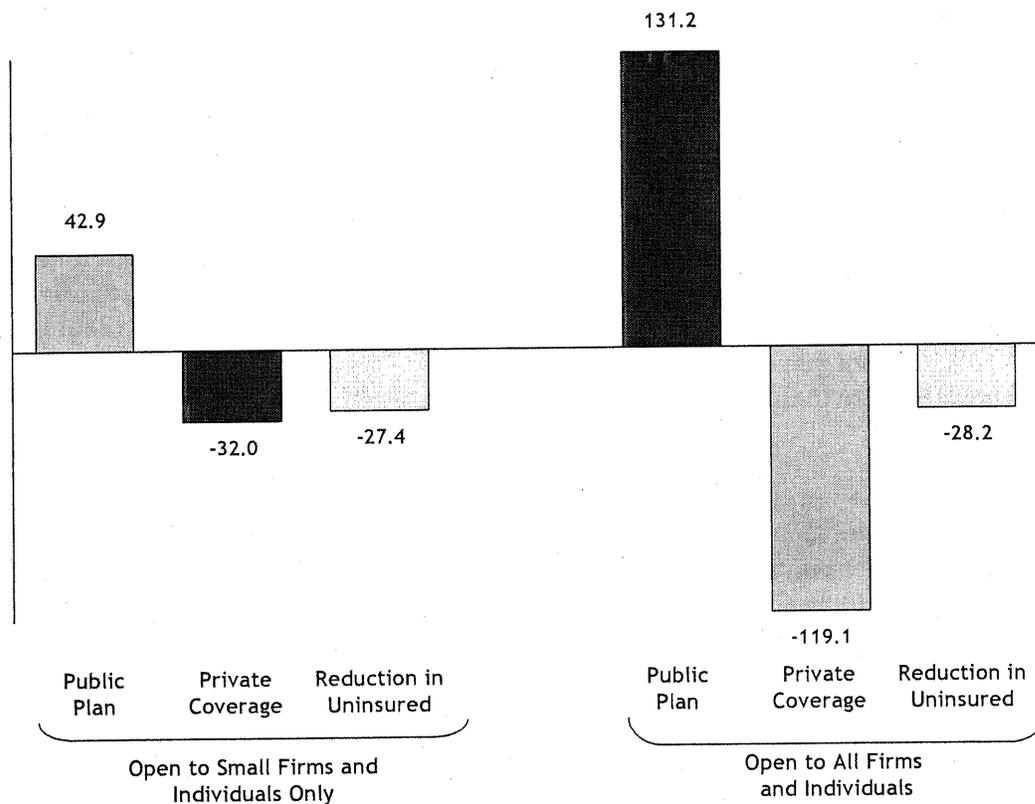
⁵ "The Health Benefits Simulation Model (HBSM): Methodology and Assumptions," The Lewin Group, February 19, 2009.

70 percent of all people currently covered under private health insurance (excludes supplemental coverage for Medicare beneficiaries).

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

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

Figure 3
Public Plan Enrollment and Reduction in Private Coverage Under a Public Plan Using Medicare Payment Levels 2010 (millions)



a/ Changes in coverage under Medicaid and other programs not shown.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

For example, the program could be implemented using private payer rates (i.e., "negotiated" rates). Under this scenario, premiums would be only about 9 percent less than in private plans, reflecting that the program would still have lower levels of administrative costs than private insurance. Public plan enrollment, assuming all firms are eligible to enroll, would fall from

131.2 million people with Medicare reimbursement levels to about 20.6 million people at private payer levels (*Figure 4*). We also show enrollment assuming payments are set at the midpoint between Medicare and private payment levels.

Figure 4
Enrollment in Public Plan Under Alternative Provider Reimbursement Scenarios

	Eligible Groups					
	Small Firms, Self-employed and Individuals Only			All Firms, Self-employed and Individuals		
	Private Payer Levels	Midpoint Payment Levels	Medicare Payment Levels	Private Payer Levels	Midpoint Payment Levels	Medicare Payment Levels
Public Plan Premiums as Percent of Private	-10%	-25%	-40%	-9%	-18%	-32%
Coverage Effects (millions)						
Reduction in Uninsured	23.8	26.1	27.4	25.1	26.7	28.2
Enrollment in National Public Plan	17.0	31.5	42.9	20.6	77.5	131.2
Change in Private Coverage	-10.4	-21.5	-32.0	-12.5	-67.5	-119.1

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

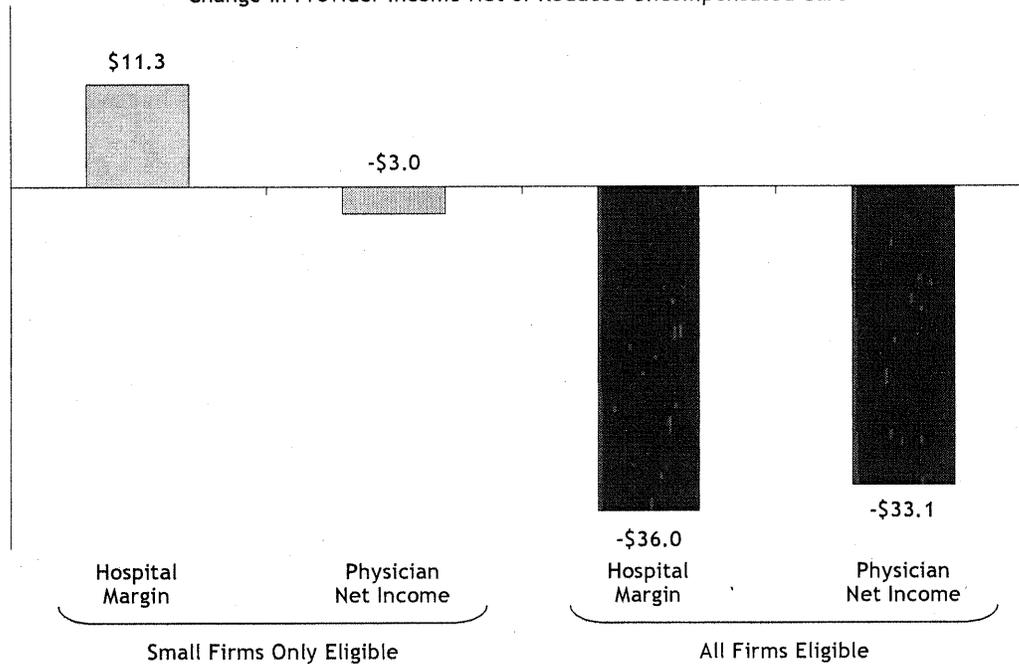
D. Provider Impacts

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

Assuming the public plan is open to all individuals and all employers, total hospital margin would fall by \$36.0 billion in 2010 (*Figure 5*). This is equal to about 4.6 percent of total hospital net revenues (i.e., gross revenues less contractual allowances) in that year. Physician net income would fall by about \$33.1 billion, which is equal to about 6.8 percent of physician revenues. Thus, under this scenario, health care providers are providing more care for more people with less revenue.

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

Figure 5
Impact of Public Plan on Provider Income if Medicare Provider Payment Rates Used
 Change in Provider Income Net of Reduced Uncompensated Care



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

In *Figure 6*, we present estimates of the impact of the program on provider incomes under alternative payment level assumptions for the public plan

Figure 6
Impact on Hospital and Physician Net Income in 2010 (billions)

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

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

E. Simulating Effects for Individuals and Self-employed

We simulate the individual's decision to enroll in the public plan by estimating the premium that these individuals would pay in the current private market for the benefits offered in the public pool. The public plan could increase coverage if it provides coverage to uninsured people at a lower cost than in the current market. This can also result in shifts in coverage from existing sources to the public plan.

1. Simulating Changes in Number with Coverage

We begin by estimating the program's effect on the number of people with coverage. We first identify uninsured people who would now be able to purchase coverage at a lower price than they would pay in the individual market under current law. We interpret this as a reduction in premiums that will cause some people to take coverage. We simulate their decision to take that coverage using research on how changes in premiums affect the likelihood of taking coverage. We assume that newly insured people will enroll in whichever coverage option is least costly.

In the next step, we identify currently insured people who would now face a higher premium. This would occur in cases where the availability of the public plan is coupled with changes in insurer rating regulations affecting the premiums in both the private market and the public plan. For example, the Obama proposal would prohibit medical underwriting, which will generally increase premiums for relatively healthy individuals now covered in the individual market. We also simulate losses of coverage for these people using the same research on how price affects the individual's decision to take coverage.

2. Allocation to Public and Private Coverage

In this step, we identify privately insured people 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.⁶ 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 HMO.

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., which averages about -2.47. This means 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. As shown in *Figure 7*, the likelihood of shifting to a lower cost plan is

⁶ Strombom, B., Buchmueller, T., Feldstein, P. "Switching Costs, Price Sensitivity and Health Plan Choice," *Journal of Health Economics*, 21 (2002), 89-116.

lowest for older and sicker people, reflecting that these groups are typically less willing to change providers. Individuals were randomly selected to shift to an HMO based upon these price changes and these price elasticity estimates.⁷

Figure 7
Health Plan Change Price Elasticity Assumptions by Age and Health Risk

Age of Participant	All Insured Groups		HMOs Only	
	Low Risk	High Risk ^{a/}	Low Risk	High Risk ^{a/}
Under 31	-5.8	-5.3	-7.0	-8.0
31 - 45	-3.9	-3.6	-5.9	-6.4
Over 45	-2.4	-2.1	-4.3	-4.5

a/ The study defines high risk people as those who have selected illness or hospitalizations. In our model, as a proxy for this definition, we assumed that people with expected spending in excess of the 80th percentile of spending are “high risk”.

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

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 these FFS plans. Similarly, people who leave HMOs for a FFS plan tend to have higher costs than those who remain with the HMO.⁸

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 benefits design or marketing practice. This will 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.

We simulate the shift of individuals from the public plan to these HMOs using the plan change price elasticity estimates presented above in *Figure 7*. This approach tends to leave higher cost individuals in the public plan, with lower cost individuals shifting to HMOs.

F. Simulating Effects for Employers

Under the public plan scenarios presented above, some or all employers would have the option of covering their workers under the public plan by paying a premium. In some cases, non-insuring employers would start to offer coverage in response to the lower premium available in the public plan. Also, many currently insuring employers will shift to the public plan to take advantage of the lower public plan premium. The approach we use to simulate the impact of

⁷ Newly insured people were randomly assigned to HMOs based upon the percentage of privately insured people who are in HMOs after we have executed our simulation for currently insured people.

⁸ 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.

the public plan on employer coverage is similar to that used to simulate coverage decisions in the individual market.

1. Simulate Changes in the Number of Employers Offering Coverage

We first identify non-insuring employers who would now be able to purchase coverage at a lower price than they would pay in the current insurance market. We simulate their decision to take that coverage due to the price reduction using studies of how changes in premiums affect the likelihood that a firm will offer coverage. We assume that newly insured people will enroll in whichever coverage option is least costly.

In the next step, we identify firms that would now face a higher premium. Under the Obama-like health reform proposal modeled here, the elimination of medical underwriting would increase premiums for younger and healthier groups while reducing premiums for older and sicker groups. We simulate losses of coverage for these people using the studies of the effect of changes in premiums on the firm decision to offer insurance.

2. Re-allocation to Public Plan

In this stage, we identify privately insured firms that would be eligible to purchase coverage at a lower cost through the public plan. We simulate these shifts in a two step process that allocates affected people into one of the following three groups:

- Employers that remain with their current private health plan rather than shifting to the public plan. (These will tend to include employers with older and less healthy workers who decide not to change their source of coverage, perhaps to retain their current physician);
- Employers that drop private coverage to enroll in the public plan due to the lower premium; and
- Employers that leave the public plan to enroll in a lower cost HMO.

In the first step, we simulate the employer decision to switch to the lower cost public plan based upon the plan change price elasticity estimates used in our individual market simulations (see *Figure 7* above). We do this by estimating the plan change price elasticity for each worker in the firm based upon the age and health status of each worker. We then use this average price change elasticity for workers in each firm to simulate the employer decision to change their source of coverage.

In the second step we model risk selection against the public plan. We assume that managed care plans would develop products that tend to attract younger and healthier people through benefits design or marketing practice. This will 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. We simulate the shift of individuals from the public plan to these HMOs using the plan change price elasticity estimates presented above in *Figure 7*.

This approach tends to leave higher cost individuals in the public plan, with lower cost individuals shifting to HMOs. This accumulation of a disproportionate share of higher cost individuals in a given plan is called "adverse selection."

Figure 8 presents our estimates of the changes in sources of coverage assuming that providers are paid according to Medicare payment levels. The figure shows the number of workers and dependents in employer plans under current law, the number who remain with their current health plan, the number shifting to the public plan and the number who leave the public plan to enroll in a lower cost HMO. The figure shows average health benefits costs for each group of firms. These data demonstrate the degree of adverse selection for the public plan, separately for fully insured and self-funded groups.

Figure 8
Workers and Pure Premiums in Firms by Type of Coverage Offered Under the Illustrative Health Reform Proposal

	Currently Insuring Firms						Currently Non-insuring Firms					
	Small Firms			Large Firms			Small Firms			Large Firms		
	Self-insured	Fully-insured	Total	Self-insured	Fully-insured	Total	Self-insured	Fully-insured	Total	Self-insured	Fully-insured	Total
All Workers in Firm and PMPM Costs: Includes Insured and Uninsured Workers in Firms												
Employees (1,000s)	1,059	23,498	35,119	55,491	35,119	115,169	0	34,705	0	12,053	46,758	
Costs	\$630	\$570	\$562	\$619	\$562	\$592	\$0	\$400	\$0	\$291	\$372	
Current Law Premium	\$630	\$537	\$519	\$619	\$519	\$572	\$0	\$437	\$0	\$385	\$423	
Policy Premium	\$630	\$517	\$514	\$619	\$514	\$566	\$0	\$436	\$0	\$383	\$422	
Public Plan Premium	\$404	\$405	\$409	\$422	\$409	\$414	\$0	\$341	\$0	\$309	\$333	
Offer Private Coverage Under Health Reform Proposal												
Employees (1,000s)	431	1,308	6,843	9,855	6,843	18,437	0	604	0	1,099	1,703	
Costs	\$289	\$780	\$614	\$406	\$614	\$507	\$0	\$670	\$0	\$354	\$466	
Current Law Premium	\$289	\$635	\$536	\$406	\$536	\$468	\$0	\$505	\$0	\$420	\$450	
Policy Premium	\$289	\$615	\$536	\$406	\$536	\$467	\$0	\$542	\$0	\$441	\$477	
Public Plan Premium	\$415	\$482	\$427	\$406	\$427	\$419	\$0	\$424	\$0	\$355	\$379	
Do Not Offer Coverage Under Health Reform Proposal												
Employees (1,000s)	47	1,347	3,097	3,291	3,097	7,782	0	20,356	0	2,922	23,278	
Costs	\$699	\$618	\$465	\$434	\$465	\$480	\$0	\$365	\$0	\$235	\$349	
Current Law Premium	\$699	\$518	\$470	\$434	\$470	\$464	\$0	\$409	\$0	\$332	\$400	
Policy Premium	\$699	\$500	\$472	\$434	\$472	\$462	\$0	\$417	\$0	\$365	\$411	
Public Plan Premium	\$354	\$392	\$375	\$392	\$375	\$385	\$0	\$327	\$0	\$295	\$323	
Offer Coverage in the Public Plan												
Employees (1,000s)	467	17,549	20,298	34,863	20,298	73,176	0	8,530	0	5,777	14,308	
Costs	\$924	\$553	\$559	\$690	\$559	\$622	\$0	\$486	\$0	\$312	\$416	
Current Law Premium	\$924	\$534	\$521	\$690	\$521	\$607	\$0	\$498	\$0	\$408	\$462	
Policy Premium	\$924	\$514	\$514	\$690	\$514	\$601	\$0	\$479	\$0	\$388	\$442	
Public Plan Premium	\$412	\$403	\$408	\$430	\$408	\$417	\$0	\$375	\$0	\$312	\$350	
Offer Private HMO Coverage												
Employees (1,000s)	115	3,295	4,882	7,483	4,882	15,775	0	5,215	0	2,254	7,469	
Costs	\$689	\$554	\$561	\$648	\$561	\$602	\$0	\$366	\$0	\$279	\$340	
Current Law Premium	\$689	\$520	\$516	\$648	\$516	\$581	\$0	\$435	\$0	\$378	\$418	
Policy Premium	\$689	\$501	\$513	\$648	\$513	\$576	\$0	\$427	\$0	\$365	\$408	
Public Plan Premium	\$353	\$393	\$408	\$420	\$408	\$410	\$0	\$334	\$0	\$295	\$322	

a/ Pure premiums include benefits costs only and exclude administration, profit and broker and agent commissions.
 Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Tuesday, April 07, 2009

Study Says Public Plan Could Cut Uninsured, Hurt Health Insurers

A public insurance option for middle-income families would help decrease the number of uninsured U.S. residents, but it also could put private insurance plans out of business, according to a **Lewin Group study** released Monday, the *AP/Seattle Post-Intelligencer* reports.

The study found that if a public plan -- open to all workers and people seeking coverage on the individual market -- was to pay health care providers at the same rates as Medicare, it would soon have about 131 million beneficiaries, while enrollment in private plans would drop.

Lewin Vice President John Sheils said that under that scenario, "The private industry might just fizzle out altogether."

A public plan paying Medicare rates would charge monthly premiums for family coverage of about \$761, compared with an average of \$970 in private plans, according to the study.

Lewin also looked at a hypothetical public plan, also paying Medicare rates, that would be limited to workers at small businesses, people seeking coverage on the individual market and the self-employed.

Under these conditions, about 43 million people would enroll in the public option, according to Lewin.

However, if this plan were to pay providers rates similar to those paid by private insurers, it would enroll 17 million people, the study found. Depending on how the plan was configured, public coverage would reduce the number of uninsured by 24 million to 28 million U.S. residents.

Although the study results are dependent on details to be decided by lawmakers, the report "could provide ammunition for critics who say a public plan would move in the direction of government-run medicine," the *AP/Post-Intelligencer* reports.

Sheils said, "Our paper is more or less written as a 'how to' manual."

President Obama has not given exact details of a public plan he would support (Alonso-Zaldivar, *AP/Seattle Post-Intelligencer*, 4/6).

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13.04.2009

The End of Private Health Insurance. Not.

Editor's Note: Jacob S. Hacker is co-director of the Center for Health, Economic, and Family Security at U.C. Berkeley; a fellow at the New America Foundation; and the editor of Health at Risk: America's Ailing Health System--and How to Heal It. He's also a regular guest contributor to The Treatment. His "Health Care for America Proposal," published through the Economic Policy Institute in early 2007, is widely considered a rough model for the reform plans many Democrats, including President Obama, have since embraced. When a recent analysis suggested that a plan along these lines would cause a rapid and radical decline in employer-sponsored insurance, we asked him for a response. Here's what he wrote:

The Lewin Group, a respected health care consulting firm, has caused a stir with a new report arguing that public plan choice--an idea embraced by leading Democrats, including President Obama and Senate Finance Committee Chair Max Baucus--could lead to a massive shift of Americans from private insurance into public coverage.

According to the group's new analysis, if all employers and individuals in the country could buy into a national public plan that paid Medicare's rates to doctors and hospitals, over 131 million Americans would enroll in the public plan. That number is half the population not covered by Medicare today, and a much higher enrollment in the new public plan than any previous analysis of proposals of this sort have come up with--including the Lewin Group's own analysis of my 2007 proposal for health care reform, a proposal that includes public plan choice and which looks a lot like, but not identical to, the proposal that President Obama embraced during the campaign. (The Commonwealth Fund has also advanced a proposal along these lines, which the Lewin Group has also examined.)

Conservatives have predictably seized on the Lewin Group's findings to argue that the proposal to have a public plan compete with private plans is a "Trojan horse" for a universal Medicare-for-all program of national health insurance. A case in point is a new editorial from the *Wall Street Journal*, titled "The End of Private Health Insurance."

But the Lewin Group's new report suggests nothing of the sort. While it does indicate that the savings from having a public plan compete with private plans could be huge (as has every previous analysis of public plan choice), it has virtually no bearing on the question of how large enrollment in the public plan would be under a reform proposal like mine, or like President Obama's campaign proposal, or like Senator Baucus's 2008 "White Paper". That's because the illustrative proposal that

the Lewin Group analyzed is fundamentally and strangely different from these proposals--in ways that assure that enrollment in the public plan will be much, much larger.

I have posted a [long \(fairly technical\) discussion](#) of the Lewin Group analysis and where it goes awry on the website of the Institute for America's Future. Readers interested in the gory details should go there. But in a nutshell, the Lewin Group looked at a hypothetical proposal in which employers could buy into a national public plan by paying the plan's premium. What's more, in the hypothetical proposal that the Lewin Group examined, new rules would be imposed on employment-based health insurance that would vastly increase the cost for some firms of providing coverage. No wonder the public plan was projected to be big!

By contrast, all the proposals that are actually on the agenda today have employers buy into an "exchange" that has both a public plan and private plans as a choice within it. Moreover, all these proposals have at least large employers enroll their workers in the exchange by paying a payroll-based contribution, not the public plan's premium. Finally, none of these proposals includes substantial new regulations on employment-based health insurance.

All these may seem like small distinctions, but they're not. They are the difference between the huge public plan that Lewin's analysis foresees, and the likely effects of the proposals that are actually being debated today--which, according to prior estimates by the Lewin Group itself, result in more Americans having private insurance after reform than they do today.

I am not sure why the Lewin Group came up with such an odd proposal so discordant with existing plans for reform (or why they described it so vaguely in their report--the details described in this post came from private correspondence with a representative of the Lewin Group). But I do know that the new report has basically nothing to say about the effects of proposals similar to mine or Senator Baucus's or President Obama's campaign plan on the distribution of public and private coverage.

--Jacob S. Hacker

Posted: [Monday, April 13, 2009 11:01 PM](#) with [2 comment\(s\)](#)

Comments

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[hmseil01](#) said:

Mr. Hacker sounds a little disconcerted. If the Lewin Group can't get it straight and health wonks can't understand it, how do you expect our reps in Congress or their constituents to decipher these convoluted proposals?

While the academics and the economists ponder and debate minutiae--but minutiae that will cost the taxpayer millions, the American people are bleeding--losing lives and treasure. Meanwhile, the private insurers are fighting tooth and nail to protect and expand their profit stream.

There can be no level playing field shared by the public option and the insurers. Right and good intentions may be on the side of the Obama --Hacker plan, but money, power and influence will be on the side of the health care industry.

Nor do I want a universal mandate serviced by the private sector. The Massachusetts mandate plan isn't affordable for mid- to low-income families. (The PBS documentary Sick in America got that right at least.)

We don't want connectors and exchanges--more bureaucray, more paperwork. We want a simplified single payer plan--easy for everyone to understand, easily implemented and affordable for families and businesses. Regional boards made up of physicians and knowledgeable clinicians and administrators will set fair reimbursement fees.

In the NY Times, Dick Gephardt suggests that any public option be a "spare plan." To whom would he offer the skimpy coverage?--To his neighbor or mine? USA Today and my local paper ran an article yesterday about all the diabetics who are forgoing treatment and cutting meds because they can't afford to do otherwise. How would Mr. Gephardt define "spare care" to a diabetic?

Keep it simple. Give everyone an expanded and improved version of Medicare. Tell the insurers that they are a nonessential. "luxury" we can no longer afford.

April 14, 2009 4:12 PM

[donmcmahon](#) said:

I find it hard to believe that the debate on this proposal is about the numeric impacts. There are several conceptual hurdles that probably need to be addressed before speculating on what the numbers will be.

Part of my problem is this nebulous concept of the health insurance "Exchange." Is the Exchange an "Assigned-Risk Pool" in insurer's vernacular? Is it just a point where insurers must accept any and all individual customers (their choice) at the insurer's community rate? Will the Public Plan be able to use their price-making ability in determining their premiums in the Exchange? Can employers opting to send their employees to the Exchange (and thus have to pay the 6 percent mandate) pay the employee's share of their premiums?

It seems to me that if the Public Plan will have price making abilities, whether in the market or in the Exchange, then they will probably have the lowest premium rates. Private insurers will be required to take any customer and charge their community rates which will not have the benefit of price-making ability. It is hard to divine the way in which private insurers will be able to compete.

Hacker touts the ability of Medicare (the Public Plan) to control hospital cost using their "concentrated purchasing power to pioneer new payment methods." If private firms used their concentrated purchasing power they might become subject to Anti-Trust law.

Hacker's argument for inclusion of the Public Plan -- because of its ability to control cost -- misses a better solution to the root problem. A significant reason that Medicare, and hence the Public Plan, can control cost is because they can control cost with rate setting ability! Rates schedules set for hospitals, that *all* insurers would pay would allow the private insurers to compete on a level playing field basis with the Public Plan.

April 14, 2009 5:58 PM

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Extended Discussion Of Lewin Group

Healthy Competition Technical Appendix

By Jacob Hacker
April 11th, 2009
Related Topics: Health Care for All Jacob Hacker

Here's a more technical discussion of the Lewin Group's new report on public plan choice for those who can't bear to miss the trees amid the forest.

First the briefest possible background: *Public plan choice* means that people who don't get coverage from their employer get the choice of enrolling in a public plan (in my vision, modeled roughly after Medicare) through some kind of new national insurance exchange (or at least I think it should be national). There would also be private plans in the exchange that people could choose. That's why I call the idea "public plan choice."

My proposal for public plan choice, "Health Care for America," is pretty much the farthest you can go with the idea. I have no special treatment of small businesses. They have the same deal as other employers: cover your workers or pay a payroll-based contribution (6% of payroll, to be exact) to cover them through the exchange—aka "play or pay." I would fold Medicaid and CHIP into the new play-or-pay system, so people who receive benefits from these programs would either get signed up for employment-based insurance or go into the exchange like other folks without workplace coverage. Obama's campaign proposal didn't fold in Medicaid and CHIP, and it exempted small employers from the contribution requirement (without, smartly, saying what counted as a "small employer"). Finally, my proposal has an individual requirement that people obtain coverage (which, because of the play-or-pay requirement, would only have really mattered for those without direct or family ties to the workforce), while Obama during the campaign said he would only require coverage for kids, though he indicated he'd be open to a broader mandate down the road.

Put simply, Health Care for America is a pure, undiluted proposal for public plan choice. So it's notable that under my proposal, according to the Lewin Group's analysis of a couple years ago, the public plan ends up with much lower enrollment in the public plan than projected in the Lewin Group's new analysis (90 million versus over 131 million). (For aficionados, the national insurance exchange in my proposal would have larger enrollment, but around 38 million people in the exchange would choose private plans instead of the public plan.)

Even more important, if I had kept Medicaid and CHIP separate from the exchange, as Obama indicated he wanted to do during the campaign, then enrollment in the public plan (again, according to the Lewin Group's analysis of a couple years ago) would have been *well less than half* the 131 million number that the Lewin Group is talking about now: just over 56 million. Since my proposal even without including Medicaid and CHIP is still more far-reaching than the Obama or Baucus proposals, 56 million should serve as the very upper-end estimate of how large the public plan would be under the proposals embraced by leading Democrats. Quite obviously, it is much, much smaller than 131 million.

So what's going on?

The first clue as to what is going on is that the Lewin Group provides wildly different projections for enrollment in the public plan based on how generously the public plan is paying providers. If the public plan pays Medicare rates, which are significantly lower than private rates, then enrollment in the public plan is huge. If it pays private rates, then enrollment is tiny.

This might seem obvious. If rates are lower, the premium for the public plan will be lower and more employers will enroll workers in the public plan. But that's not how play-or pay works. Yes, the price of the public plan affects whether folks in the exchange choose it. But the really crucial question for knowing how big the public plan will be is *how many people are in the exchange in the first place*. And in a play-or-pay proposal, that's determined not by what coverage in the exchange costs, but by what employers have to "pay" if they don't "play"—that is, what payroll-contribution rate they have pay to enroll their workers in the exchange if they decide not to offer coverage.

Assuming employers are indifferent between offering coverage on their own or paying the payroll-based contribution (which is what most analyses of play-or-pay proposals, including the Lewin Group's previous analysis of mine, assume), then employers will put their workers in the exchange when the payroll-based contribution is less than it would have cost them to provide coverage on their own. The premium for the public plan matters not at all here, and neither, therefore, does the level of the public plan's payments for medical services.

(Yes, yes, in a larger sense, the payroll-based contribution rate could be affected indirectly by what the public plan's premium turned out to be, because if insurance through the public plan was cheaper, you could finance expanded coverage with a lower tax rate—or lower payments from other sources, since nobody thinks the payroll-based contribution will or should cover a huge amount of the total cost of coverage. Or you could offer better benefits than you originally envisioned. Whatever. But when you are designing legislation, or modeling a proposal, you have to say what the rate is. And it's the rate, not the premium of the public plan, that will affect the decision of employers subject to the play-or-pay requirement.)

Well, you might say, perhaps the Lewin Group just assumed that the play-or-pay requirement would apply only to larger firms, which is what Obama suggested should be done during the campaign (again, without saying what a "small firm" is). This in fact seems to be what the Lewin Group is assuming: On page 2, they say "we assume the following" and then "[l]arge employers are required to offer insurance or pay a payroll tax." (By "large," The Lewin Group means 10 or more workers.) In the Lewin Group's analysis, then, smaller firms, rather than have to choose between paying or playing, would be able to voluntarily enroll their workers directly into the exchange. They don't have to play but they can pay to cover their workers.

Now I had always thought that if this were the policy ("no need to play but yes, you can pay"), then small firms would buy into the exchange on the same terms that large firms did—that is, by paying the payroll-based contribution. But the new Lewin Group analysis assumes instead that small firms would just have to pay the premium for the public plan to enroll their workers in it. Allowing small firms to buy into the public plan by paying the premium might be a more generous policy than requiring

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that they pay a payroll-based contribution, depending on what the contribution rate and wages of the firms were, and so perhaps this could increase the number of small firms going into the exchange, especially if you gave them a lot of subsidies for covering their workers (The Lewin Group assumes that tax credits would be provided to small employers with low-wage workers.)

But if we're focusing just on small firms and individuals without ties to the workforce, we're still talking about a pretty small part of that big 131 million number. According to the Lewin Group "if eligibility is limited to only small employers, individuals, and the self-employed, public plan enrollment would reach 42.9 million." Put another way, roughly 90 million of the folks that the Lewin Group thinks are going into the public plan are working for large (in their definition of "large" as 10 or more workers) employers.

And that's when I found the feature of the Lewin Group report that is really baffling. The payment levels paid by the public plan matter for large firms too. Check out Figure 4 in the report (reproduced below). If you look at the row that says "enrollment in national public plan" you will see that the public plan enrollment rises across the first three columns as the payment rates of the public plan go down to Medicare payment levels. These first three columns are for a proposal that only includes small firms, the self-employed, and individuals—the proposal that the Lewin Group says would result in 42.9 million in the public plan. As I've said, if the convoluted scenario I have described above for the treatment of small firms were really what was put in place (hey, small firm, you can buy bargain-basement coverage from us), then I could see something like this happening. Lower payments mean lower public plan premium, which means more small employers enrolling their workers in the public plan (and more individuals and the self-employed coming in); ergo, bigger public plan.

Figure 4
Enrollment in Public Plan Under Alternative Provider Reimbursement Scenarios

	Eligible Groups					
	Small Firms, Self-employed and Individuals Only			All Firms, Self-employed and Individuals		
	Private Payer Levels	Midpoint Payment Levels	Medicare Payment Levels	Private Payer Levels	Midpoint Payment Levels	Medicare Payment Levels
Public Plan Premiums as Percent of Private	-10%	-25%	-40%	-9%	-18%	-32%
Coverage Effects (millions)						
Reduction in Uninsured	23.8	26.1	27.4	25.1	26.7	28.2
Enrollment in National Public Plan	17.0	31.5	42.9	20.6	77.5	131.2
Change in Private Coverage	-10.4	-21.5	-32.0	-12.5	-67.5	-119.1

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

But now move to the right along the row and look at the next three columns. They show the change in public plan enrollment as rates come down to Medicare levels (lowering the cost of the public plan) under a proposal that applies to *all firms*. In this proposal, the large firms that are subject to the play-or-pay requirement are brought in. So we should definitely see more people go into the public plan under this scenario. What we should not see is what the columns show, that the number of people in the public plan rises as the payment levels of the public plan (and hence its premiums) fall. This is exactly what I just said *cannot* and *does not* happen under a play-or-pay proposal. The cost of the public plan has no direct bearing on the decision of employers who are subject to the play-or-pay requirement. They only care what the "pay" option entails, which is determined by the payroll contribution rate—not, I repeat not, by the public plan's premium.

Puzzled, I wrote the Lewin Group. I received a quick and gracious reply that cleared up what was going on, but left me equally puzzled about why the Group came up with the very odd hypothetical puzzle that they did.

Here are the key details of the proposal that the Lewin Group analyzed:

1. There is no exchange with private plans alongside a public plan. Employers and individuals simply buy into the public plan.
2. To buy into the public plan, all employers and individuals just pay the premium for the public plan (with subsidies for small low-wage firms and low-income individuals).
3. Employment-based health insurance would be community rated, meaning all firms would pay the same rate for the same benefit, regardless of the health status of their workers.
4. If a large firm (10 or more workers) didn't provide coverage, it would pay a fine of 6% of payroll. However, this fine would not be applied to the cost of coverage.

So the Lewin Group's hypothetical proposal assumes that all employers can buy into the public plan by paying its premium. There is no exchange—a key feature of Obama's campaign proposal, my plan, Senator Baucus's plan, and just about every other leading reform proposal. Odder still, the Lewin Group proposal says that larger employers that don't provide coverage have to pay a 6% tax *but that the tax is simply a fine, not a payment for coverage*.

In other words, Lewin Group completely ignored the play-or-pay requirement. They assumed not just that small employers could buy into the public plan directly at the public plan's premium, which is a strange assumption since it ignores the exchange and private plans within the exchange altogether. When they turned to the hypothetical proposal that gave them the headline-popping 131-million figure, they assumed that *all firms*—even large firms—could buy into the public plan directly simply by paying the public plan's premium. Meanwhile, they treated the play-or-pay requirement not, in the proper way, as a central financing mechanism of reform that involves employers that don't provide coverage paying a payroll-based contribution to cover their workers. Instead, they treated it, in essence, as a fancy penalty system for large employers.

Finally, and equally strange, the Lewin Group assumed that employment-based insurance would be subject to a rule known as "community rating"—that is, all employment-based plans would have to charge the same rate for the same benefits, without variation based on the health status of enrollees. A firm with healthy workers would pay the same amount for private coverage as a firm with less healthy workers. This, of course, raises the cost of private coverage for large firms that have healthy workforces, and thus (once again) increases enrollment in the public plan.

But that's not an idea that Obama or any other reformer that supports the broad play-or-pay reform framework has embraced. Premiums would be community-rated in the exchange and in the individual market, but not in the employment-based insurance market.

In short, the Lewin Group's hypothetical proposal has three features that guarantee the public plan will be big. Whatever "131 million enrollees in the public plan" represents, it does not represent an accurate picture of Obama's campaign

pronouncements, or Max Baucus's "White Paper," or my plan, or any other proposal under serious consideration today.

To get an estimate of how many people will end up in the public plan, therefore, we need to go back to the Lewin Group's analyses of proposals more or less like what Obama proposed during the campaign—namely, play-or-pay plans with an exchange that features a competing public plan, and without extensive new rules on employment-based insurance. Those analyses (of my proposal or the Commonwealth Fund proposal) show that enrollment in the public plan is likely to be much, much smaller than the Lewin Group's analysis estimates. Indeed, if you look at the Lewin Group's analysis of my proposal (again, the maximalist public plan choice approach), more Americans have private insurance after reform than do before—either through their employer or through the new national insurance exchange.

What's more, these are probably upper-bound estimates of the size of the public plan, since the Lewin Group assumes that employers are indifferent between providing coverage directly and paying into a public program. If, as I suspect, employers prefer to provide benefits directly and gaining the goodwill of their workers by doing so, rather than paying a tax to let government sponsor those benefits, then enrollment in the public plan is going to be even lower. (How much credit do employers get for their contribution to Social Security, after all?)

In sum, the Lewin Group's report confirms what we knew already: public plan choice will save big money. Unfortunately, however, the Lewin Group's report doesn't cast any new light on the issue that has gotten the report the most attention: how many people will be in the public plan. Public plan choice will help make coverage more affordable and slow the increase of health costs. But it's not going to massively displace employment-based health insurance—at least if we adopt the real policies advocated by leading reformers, rather than strange hypothetical policy outlined by the Lewin Group.

There's just one final puzzle: Why did the Lewin Group analyze a proposal that's not on the political agenda? (The proposal closest to the one the Lewin Group tried to analyze is Pete Stark's modified "Medicare-for-All" proposal, which would allow employers to buy into Medicare.) I don't know, but I find the obvious conspiratorial responses unlikely. No, I think the reason is probably more conventional than conspiratorial and therefore worrisome in its own way. I think the Lewin Group wanted a big media hit, and they certainly got one. But what their success shows is that on health care, the media just doesn't have the intellectual wherewithal to dig deep into statistical models of health policy. Instead, journalists are likely to report the "top lines" without more than a passing interest in where they come from. We're going to be seeing a lot more of this in the coming weeks. Let's hope that our political leaders won't lose sight of the necessity of health care reform in the fog of biased and badly done analyses.

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