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COST IMPACT ANALYSIS FOR THE "HEALTH CARE FOR AMERICA" PROPOSAL

Final Report

Prepared for:
The Economic Policy Institute

Submitted by:
The Lewin Group, Inc.

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EXECUTIVE SUMMARY

Under the Health Care for America Proposal, employers would be required to provide coverage or pay a payroll tax to have their workers covered under a newly created national health insurance pool called Health Care for America (HCA). Modeled on Medicare, Health Care for America would offer a single Medicare-like fee-for-service option (public HCA plan) and a selection of Health Maintenance Organizations (HMOs) or other private managed care plans (private HCA plans). People who do not have employer-sponsored insurance (ESI) would be covered under HCA, including those now covered under Medicaid and the State's Children's Health Insurance Program (SCHIP). The Proposal would provide subsidies for worker HCA premiums for those living below 300 percent of the Federal Poverty Level (FPL), and premium subsidies for non-workers enrolled in HCA who are living below 400 percent of the FPL.

We estimate that there were about 47.8 million uninsured people in the country in 2007. The Health Care for America (HCA) Proposal would reduce the number of uninsured by 46.5 million people (i.e., 97.3 percent of the uninsured), leaving only about 1.3 million people uninsured. Coverage under the proposal would be as follows:

- We estimate that 122.2 million people would be covered under ESI, compared with 157.0 million people under current law;
- About 128.6 million people would be covered through the newly created HCA pool; and
- Enrollment in Medicare and the TRICARE program (i.e., military retirees and dependents) would remain the same as under current law.

The Health Care for America Proposal would cover 46.5 million uninsured people without increasing national spending for health care, largely through lower provider reimbursement, administrative simplification and other features of the proposal. The spending effects of the Proposal include:

- Spending for health care services and prescription drugs nationally would increase by $53.2 billion in 2007 as the uninsured become covered;
- Administrative simplification would reduce administrative costs by about $25.4 billion in 2007;
- There would be additional savings of $27.9 billion due to changes in provider payments, requiring people to have and use a medical home, and government negotiation of prescription drug prices for people covered through HCA.

Federal government health spending would increase under the Health Care for America Proposal by $49.3 billion, after accounting for all offsets. Total program spending under HCA would be $417.7 billion in 2007 including benefits and administration. These costs would be offset by the following:

- Employer payroll taxes for firms that do not provide coverage ($106.8 billion);
- Premiums for individuals covered through HCA ($80.3 billion);
- Federal and state government savings to Medicaid and SCHIP that would be transferred to HCA ($160.1 billion); and

- Other savings and new federal revenues under the Proposal ($21.2 billion).

We estimate that state and local governments would save $21.2 billion as a result of savings to programs that traditionally serve the uninsured (i.e., safety net programs). There would be no immediate net savings to Medicaid and SCHIP for states because they are required to pay the amount saved to HCA to help fund the program (i.e., maintenance of effort for Medicaid SCHIP only). Over time, however, savings achieved by HCA would be shared with the states.

Overall we estimate that private employers spent about $442.7 billion on health care for workers and retirees in 2007 (excludes employee contribution). Under the Health Care for America Proposal, private employer health spending would decrease by $10 billion, reflecting that many firms will find it less costly to discontinue their health plans and pay a six percent payroll tax to enroll their workers in HCA. Changes in private employer spending include:

- Private employers who currently offer coverage would save $65.6 billion by discontinuing their insurance and enroll their workers in HCA by paying the tax;
- Private employers that currently do not offer coverage would spend $55.6 billion more due to the requirement that they either provide coverage or enroll their workers in HCA by paying the payroll tax;
- On average, firms that currently offer coverage would save $809 per worker and those that do not currently offer coverage would spend $1,568 more per worker.

The Health Care for America Proposal requires that individuals obtain coverage and automatically enrolls people who do not have insurance into the public HCA plan. It also provides subsidies to help low-income people pay premiums. Overall, families would save $23.3 billion primarily from lower out-of-pocket payments. However, other financing mechanisms that would be needed to fully fund the proposal (i.e., $49.3 billion) would reduce these savings to families.

The Health Care for America Proposal would control the growth in health spending as enrollment increases, by restricting provider payment increases, negotiating deeper drug discounts, and simplified administration. Thus, national health spending under the HCA Proposal will be lower than under current law. We estimate that under these cost controls, total national health spending over the 2008 through 2017 period would be about $1.04 trillion less than under current law over that same period.

I. DESCRIPTION OF THE "HEALTH CARE FOR AMERICA" PROPOSAL

The Proposal would create Health Care for America (HCA), which would be a new national health insurance pool modeled after Medicare. Health Care for America would offer a single Medicare-like Fee-For-Service option (public HCA plan) and a selection of Health Maintenance Organizations (HMOs) or other managed private plans (private HCA plans). The private HCA plans would be required to offer at least the same benefits as the public HCA plan, with no greater cost sharing (overall or by service type). People who do not obtain coverage voluntarily would be automatically enrolled in Health Care for America. Low-income enrollees would receive subsidies to help pay their premiums on a sliding scale based on income. All enrollees would have their copayments capped so as not to exceed a certain percentage of family income. The Proposal would ensure health care coverage for all U.S. residents, including non-citizens.

Under the Health Care for America Proposal, employers would be required to provide coverage or pay a payroll tax to have their workers covered under Health Care for America (commonly referred to as "pay-or-play"). All workers would either be covered through their qualified Employer-Sponsored Insurance (ESI) or under Health Care for America. To qualify, the ESI plan must be actuarially equivalent to the HCA benefits standard and the employer must contribute at least 75 percent towards the cost of coverage for single coverage (66 percent for family coverage) for full-time workers (i.e., those working at least 20 hours/week). The employer contribution would be prorated for part-time workers by a one percentage point reduction for each hour under 20 hours. For example, for an employee working 10 hours/week, the employer must contribute 56 percent of the cost of family coverage (i.e., 66 percent minus hours worked under 20). Employers who offer coverage through Health Care for America would be allowed to offer additional supplemental benefits. However, they would not be allowed to cover some workers through Health Care for America (e.g., part-time workers) and cover others under private ESI plans. A worker would be allowed to opt out of private ESI coverage under the Proposal only if the worker has alternative coverage through a spouse's plan including Medicare or military coverage (namely TRICARE/CHAMPUS). Early retirees would be covered either through employer-sponsored retiree coverage or through Health Care for America.

The Proposal would transfer all current beneficiaries of Medicaid and the State Children's Health Insurance Program (SCHIP) into Health Care for America. Uninsured workers and dependents, including the self-employed, would be automatically enrolled into Health Care for America or their qualified ESI plan by their employer. States would automatically enroll low-income residents, using information from other income-tested programs such as food stamps. Uninsured non-workers and people who do not file taxes would be enrolled in Health Care for America through state unemployment programs, and when they access inpatient hospital services at the point of service.

Health Care for America would be financed primarily through employer payroll taxes and family premium contributions. We present key provisions of the Proposal in the following sections:

- Coverage and Benefits;
- Premiums, Subsidies and Cost-Sharing;
- Provider Payments;
- Financing; and
- Administrative Simplification

A. Coverage and Benefits

Under the Proposal, employers would be required to offer coverage or pay a payroll tax to enroll their workers into Health Care for America (commonly referred to as employer "pay-or-play"). The Proposal would require that all U.S. residents, including non-citizens, have health care coverage. Automatic enrollment mechanisms would be instituted to assure coverage for everyone, as follows:

- Medicaid and SCHIP beneficiaries would be automatically enrolled into Health Care for America by the state;
- States would use income-tested programs such as food stamps to automatically enroll low-income people into Health Care for America;
- Uninsured non-workers and people who do not file taxes would be automatically enrolled at point of service and through unemployment programs; and
- Employers would automatically enroll workers who do not take up coverage unless the worker has private coverage through a spouse, covered through Health Care for America, Medicare or CHAMPUS.

Covered services under Health Care for America would include the services under the current Medicare program as well as comprehensive mental health, maternal and child health services and comprehensive prescription drug coverage, subject to a formulary.[1] Medicaid would continue to provide wrap-around services to Medicaid/SCHIP beneficiaries enrolled in Health Care for America.

People who are not working or are self-employed would have the option either to buy into Health Care for America or purchase at least "actuarially equivalent," private non-group coverage. To be considered "actuarially equivalent," the private non-group plan must include all covered services under the public HCA plan, but may include additional services. Actuarially equivalent private plans could have different copayment requirements, but cannot have greater cost sharing overall or within service type.

B. Premiums, Subsidies and Cost Sharing

Premiums differ for workers obtaining Health Care for America coverage through their employer (including self-employed people) and non-workers because the employer pays a

[1] Under the Health Care for America benefits package, copayments for outpatient mental health will be 20% where as copayments under Medicare are 50%. The HCA prescription drug benefit will not include a 'doughnut hole' such as that in Medicare Part D benefit.

payroll tax contribution for its workers. However, all premiums, for workers and non-workers, would be paid after-tax. Worker premiums, which would be collected through employer withholding, would be as follows:

- No premium would be required for workers with income below 200 percent of the Federal Poverty Level (FPL); and
- Premiums for workers above 200 percent of FPL would be as follows, and would be phased-in based on family income between 200-300 percent of FPL.

Family Type	Premium
Individual	$70 per month
Couple	$140 per month
Single Parent	$130 per month
Two-Parent Family	$200 per month

Families would decide how to enroll children. However, under the premium structure above, splitting up the family may cause individuals to pay more in monthly premiums but not less, as illustrated in the example below:

Enrollment	Premium
Example: 2-parent/2 child family	
Option 1	
Individual	$70 per month
Single Parent (parent + children)	$130 per month
Total premium	$200 per month
Option 2	
Two-Parent Family	$200 per month
Total premium	$200 per month
Option 3	
Couple	$140 per month
Individual (child 1)	$70 per month
Individual (child 2)	$70 per month
Total Premium	$280 per month

Health Care for America premiums for non-workers are based on the average cost for all Health Care for America enrollees (workers and non-workers) for the benefits provided in the public HCA plan. Premiums for non-workers would vary by family composition only (i.e., premiums would be community-rated). Non-workers whose family income is under 100 percent of the Federal Poverty Level (FPL) would not pay a premium. The premium would be phased-in based on family income between 100 percent and 400 percent of FPL. Families with incomes over 400 percent of the FPL would pay the full cost of the premium. Our estimated monthly HCA premiums used for the analysis are presented below.

	Estimated Monthly HCA Premium for Non-workers in 2007 [a/]				
Family Type	Below Poverty	100-199% FPL	200-299% FPL	300-399% FPL	400% FPL & Over
Individual	none	$45	$135	$225	$270
Couple	None	$90	$270	$450	$540
Single Parent	None	$75	$220	$385	$460
Two-Parent Family	None	$110	$335	$560	$670

a/ Premiums are phased-in on a sliding scale for families between 100-400% FPL. Illustrative premiums above are based on the midpoint of the income ranges (e.g., 150%, 250% and 350% FPL).

Most non-workers enrolled in Health Care for America would have low incomes and thus their premiums would be highly subsidized. We estimate that 53 percent of non-workers that would enroll in HCA would have annual family incomes below the FPL and thus pay no premium. Another 23 percent would have incomes between 100 and 200 percent of the FPL and would be charged modest premium amounts. About 16 percent would have incomes between 200 and 400 percent of the FPL and would pay gradually increasing premiums, and 8 percent would have incomes over 400 percent of poverty and would pay the full community-rated premium.

Cost-sharing under Health Care for America, except for preventive services, would be as follows:

- A $350 deductible per individual ($500 per family);
- A 20 percent coinsurance for outpatient services;
- No coinsurance would be imposed for hospital stays; however, hospital stays would be subject to the deductible; and
- Maximum out-of-pocket limits would be $3,500 per individual ($5,000 per family).

Families below poverty would only pay modest copayments ($1 per visit). In addition, out-of-pocket cost-sharing would be limited as follows:

Family Income Level	Maximum Out-of-Pocket Spending Limit
100 – 150 percent FPL	2.5 percent of income
151 – 300 percent FPL	5.0 percent of income
Over 300 percent FPL	7.5 percent of income

Finally, the HCA Proposal does not prevent enrollees from purchasing supplemental coverage either through their employer or through private individual insurance to further reduce their exposure to out-of-pocket costs. However, for this analysis, we assumed that HCA enrollees do not purchase supplemental coverage.

C. Provider Payments

The public HCA plan would pay Medicare payment levels for Medicare fee-for-service benefits, as well as full mental health, maternal and child health services, and full prescription drug coverage. The plan would bargain for lower prices for prescription drugs using an approach such as that used by the Veteran's Administration. In addition, drugs would be subject to a formulary.

We assume that payments from Health Care for America to private HCA plans would be equivalent to what would be paid to cover individuals through the public HCA plan. Payments to private HCA plans are assumed to be made on a risk-adjusted basis.

D. Financing

The Proposal would be financed partly through employer payroll taxes. Employers who do not offer coverage would be required to pay a 6 percent payroll tax. Health Care for America premium payments from employees and individuals would be used to fund the program. States would also be required to maintain their funding levels under the Medicaid and SCHIP programs to help fund the program. In addition, Federal Financial Participation would be available for wrap-around services provided to Medicaid/SCHIP beneficiaries enrolled in the Plan. Other potential funding sources for the program may include alcohol and tobacco taxes, other dedicated taxes, and general revenues. However, we did not model revenues from these additional sources.

CASE EXAMPLES FOR FINANCING WORKER COVERAGE WITH THE PAYROLL TAX

1. David's firm ACME offers "actuarially equivalent" ESI coverage. Does he have to take coverage? Yes, David must take coverage through his employer *unless* he can show that he has family coverage through his spouse Mary.

- If Mary's family coverage is through Health Care for America, David's firm ACME would pay the 6 percent payroll tax to Health Care for America.
- If Mary's family coverage is through a qualified ESI plan and David shows proof of coverage in Mary's plan to ACME, David's employer ACME and Mary's employer are free to arrange transfer payments, if they desire.

2. Mary's firm does not offer any coverage. David's firm ACME provides coverage to its workers under Health Care for America. Mary's firm would pay a 6 percent payroll tax to Health Care for America to cover Mary.

3. Joe has two jobs working for ACME and FIRM. ACME provides coverage to its workers through Health Care for America by paying the 6 percent payroll tax on Joe's covered wages to provide coverage to him. FIRM would also have to contribute 6 percent of Joe's covered payroll tax to Health Care for America.

4. Bob is a member of the military (members of the military are covered by TRICARE/CHAMPUS). Bob also works for ACME. ACME does not provide coverage. ACME would pay the 6 percent payroll tax to Health Care for America, which would then be transferred to TRICARE/CHAMPUS).

E. Administrative Simplification

The HCA Proposal would require all individuals to have coverage and would require employers who do not offer coverage to pay a 6 percent payroll tax to enroll their workers into Health Care for America. There are several options to simplify administration under the employer pay-or-play model. Under the Proposal, workers in firms that decide to pay the tax would be automatically enrolled in to Health Care for America. This would require monthly transactions of lists of workers and dependents from all firms that do not offer coverage for roughly 3.5 million employers (mostly small). People would also have to apply to Health Care for America when they become unemployed, which again would require millions of enrollment and disenrollment transactions performed monthly that must be processed in real-time so all have coverage in each month.

The cost of administering such a system could be prohibitive, if not simplified in some way. Also, the time involved to apply for premium assistance is bound to result in periods of uninsurance. To address this issue, administrative mechanisms could be designed to assure prompt transitions in coverage for people changing employment status, which we discuss below.

All U.S. residents would be enrolled in the public HCA plan from birth as a default source of coverage which never terminates and would be free to switch to a private HCA plan if they chose. People in firms that decide to offer coverage rather than pay the tax would be accommodated through coordination of benefits processes. Employers who decide to cover their workers would submit lists of covered workers and dependents that would be transferred to Health Care for America. People are then flagged as people with private employer coverage and would not be eligible for benefits in those months. (Insuring firms currently develop these lists to identify eligible people for their Third Party Administrators.)

If so flagged in the month, Health Care for America would not pay any claims for these people through the public or private HCA plans. Otherwise, they would be assumed to be covered under an HCA plan and eligible for reimbursement, even though no contact has been made with the individual. Flagged people would be responsible for assuring that the claim is sent to the right insurer.

This simplifies the administration of the Proposal in several ways.

- First, the small firms that decide to pay the tax instead of covering their workers would not need to file the names of workers and dependents of workers with Health Care for America (neither quarterly nor monthly). Their workers/dependents would be automatically covered through Health Care for America in any month they have not been flagged as covered under an employer plan. This is important because non-insuring firms tend to be small and are typically the least well equipped to perform monthly filings, etc.;
- Second, people would not need to "apply" to Health Care for America for coverage during a period in which they are not working. They are automatically covered under the public HCA plan as long as they have not opted for a private HCA plan and no employers claim they are covering them; and
- Any errors in classification by source of insurance, for both workers and non-workers, can be resolved after the fact, without leaving a person uninsured for a period, using an annual reconciliation process based on tax information.

While in Health Care for America, premiums less any subsidies could be determined as part of the federal tax and withholding system. People would face a new worksheet on the tax form that determines the premium, less subsidy, required to cover them during the months they are not covered under a private employer plan. The W2 form could be modified to indicate months of private ESI coverage. The individual would be expected to withhold the amount due for the premium (less subsidy) subject to standard IRS penalties (this could be worked into the withholding forms). No premium would be paid on the tax form for the months they had private ESI coverage.

The fact that many lower-income families do not file taxes would not affect the administrative processes described above. This is because individuals and families with income that is too low to pay taxes would be fully subsidized in Health Care for America. The Proposal would not require that workers under 200 percent of the FPL or non-workers under 100 percent of the FPL pay premiums. In addition, because premiums would be paid through withholding, low income, non-workers would be automatically relieved of making their contribution to the premium while unemployed (i.e., there would be no job and consequently, no withholding).

Any stigma that would be associated with applying for assistance (i.e., the low-income subsidy) would be eliminated. An annual reconciliation process based on tax information would be instituted to make sure that enrollees have paid the appropriate premium in the previous year. Workers who overpaid would be refunded the difference, while those who underpaid would be charged the additional amount, which would be taken directly out of any tax refund due. In case of significant underpayments (to be established), a penalty may also be imposed. Additional steps may be needed to detect fraud under the Proposal.

II. METHODOLOGY AND ASSUMPTIONS

We used The Lewin Group Health Benefits Simulation Model (HBSM) to analyze the costs and coverage impacts of the Proposal. The HBSM is a micro-simulation model of the US health care system. It is a fully integrated platform for simulating policies ranging from narrowly defined Medicaid coverage expansions to broad-based reforms, such as changes in the tax treatment of health benefits. Below, we provide more detail on the HBSM and how it was used to model key aspects of the Proposal. A more detailed documentation of the full model is available upon request. We also describe the assumptions used to estimate impacts on households, employers, and the state and federal governments. We present the methods and assumptions used to simulate the effects of the Proposal in the following sections:

- The Health Benefits Simulation Methodology
- Premiums and Subsidies
- Individual Take-Up
- Employer Decision to Offer Coverage
- Utilization of Health Services
- Wage Effects
- Provider Payments
- Prescription Drugs Purchasing
- Medical Home Requirement
- Administration
- Public Financing

A. The Health Benefits Simulation Methodology

HBSM was created to provide comparisons of the impact of alternative health reform models on coverage and expenditures for employers, governments and households. It facilitates comparisons of alternative health reform initiatives by using uniform data and assumptions. For example, take-up rates for Medicaid and various tax credit/premium proposals are simulated using uniform take-up equations and modules. Uniform methods are also used to simulate changes in health services utilization attributed to changes in coverage status and cost-sharing parameters. This uniform approach assures that we can develop estimates of program impacts for very different policies using consistent assumptions and reporting formats. The use of uniform processes also enables us to simulate the impact of substantially different policy options in a short period of time.

The key to the design of the HBSM is a "base case" scenario depicting the distribution of health services utilization and expenditures across a representative sample of households under current policy for a base year such as 2007. We developed this base case scenario based upon recent household and employer data on coverage and expenditures. We also "aged" these data to be representative of the population in 2007 based upon recent economic, demographic and health expenditure trends. The resulting database provides a detailed accounting of spending in

the US health care system for stakeholder groups. These base case data serve as the reference point for our simulations of alternative health reform proposals.

The HBSM first simulates how these policies would affect sources of coverage, health services utilization and health expenditures by source of payment. For instance, it simulates enrollment in voluntary programs, such as tax credits for employers and employees, based upon multivariate models of how coverage for these groups varies with the change in the cost of coverage (i.e., modeled as the premium minus the tax credit). In addition, the model simulates enrollment in Medicaid and SCHIP expansions based upon a multivariate analysis of take-up rates under these programs, including a simulation of coverage substitution (i.e., "crowd-out").

Once changes in sources of coverage are modeled, HBSM simulates the amount of covered health spending for each affected individual, given the covered services and cost-sharing provisions of the health plan provided under the proposal. This includes simulating the increase in utilization among newly insured people and changes in utilization resulting from the cost sharing provisions of the plan. In general, we assume that utilization among newly insured people will increase to the level reported by insured people with similar characteristics. We also simulate the impact of changes in cost sharing provisions (i.e., co-payments, deductibles, etc.) on utilization.

Changes in employer costs are assumed to be passed on to workers in the form of changes in wage growth over time. For example, policies that increase employer costs would result in a corresponding reduction in wages for affected workers, with a corresponding reduction in income and payroll tax revenues. Similarly, reductions in employer costs are assumed to be passed on to workers as wage increases. HBSM also includes a tax module that simulates tax effects due to these changes in wages. The model will simulate wage pass-through under varying assumptions on how long it would take for the labor markets to adjust.

The model includes a simulation of health insurance premiums in the private small group and individual markets using the range of rating practices permitted in each state. This permits us to simulate the impact of options for implementing rate compression proposals. It is also designed to simulate "adverse selection" that may result under policies that give employers and/or individuals a choice of alternative insurance pools with their own unique rating practices.

B. Premiums and Subsidies

We used Health Care for America premiums for workers and non-workers specified above. Because Health Care for America uses Medicare provider payment levels and a simplified administrative structure (described below), the average premiums would be about 23 percent lower than comparable private insurance for the same set of benefits for the same population. We estimate average enrollee costs in Health Care for America would be about $3,250 compared to $4,230 under a private insurance product in 2007.

Health Care for America provides premium subsidies that would be phased in for workers with family income between 200 percent of the FPL and 300 percent of the FPL. Premium subsidies are phased in for non-workers with family incomes between 100 and 400 percent of the FPL. We assumed a linear phase-in schedule for workers between 200 and 300 percent of the FPL and for non-workers between 100 and 400 percent of the FPL.

We used a multivariate analysis of the likelihood that non-workers would purchase coverage based on the change in the price of insurance. The change in the price of insurance was computed as the difference between premiums the non-worker would face in the current insurance market and the Health Care for America premiums. As described above, Health Care for America premiums would be lower than comparable private insurance due to lower provider payment rates, administrative costs and low-income subsidies. However, Health Care for America premiums are community rated so that younger and healthier people may still find private insurance to be less costly.

To simulate the change in coverage for uninsured people in the HBSM household data, we assumed that the difference in Health Care for America premiums and private insurance market premiums were treated as a reduction in the cost of insurance to eligible people. This reduction in price would result in an increase in the likelihood that such people would purchase coverage. The model was used to estimate the premium faced by each uninsured, non-working individual and family in the individual market and the Health Care for America premium that low-income people would pay. Affected individuals were then randomly selected to become covered based on the change in the net cost of insurance to the individual or family and the price elasticity assumptions discussed above. This step involved the following assumptions:

- We used actuarial estimates of the premium that individuals face in the non-group market for a benefits package like that offered under the Medicare program, with preventive health, mental health, as well as maternal and child health, and varied the premium by family composition only.
- All HBSM simulations were performed on a month-by-month basis to account for people who are eligible only part of the year. (The various premium subsidies proposals typically pro-rate the annual subsidy over months of eligibility).

C. Individual Take-Up

The Proposal would require employers to cover individuals or pay a payroll tax and cover all U.S. residents. As a result, we assumed that all uninsured people would take coverage from the source available to them or be automatically enrolled in Health Care for America. While assuring that each individual obtains coverage probably is not possible, compliance would be greatly enhanced by the automatic enrollment of uninsured workers under the Proposal through the process of collecting tax revenues from employers, as well as through automatic enrollment through other income-tested programs. However, it would be more difficult to ensure coverage for uninsured non-workers.

We estimated the likelihood that an individual would take coverage under the HCA Proposal based upon a multivariate analysis of how the likelihood that an individual would take coverage varies with the amount of the premium (commonly referred to as "price elasticity"). This estimate is based upon a pooled, time-series, cross-section analysis of private employer coverage reported in the Current Population Survey for the 1987 through 1997 period.[2] These analyses indicate an overall price elasticity of -0.34 percent, which means that on average, a one

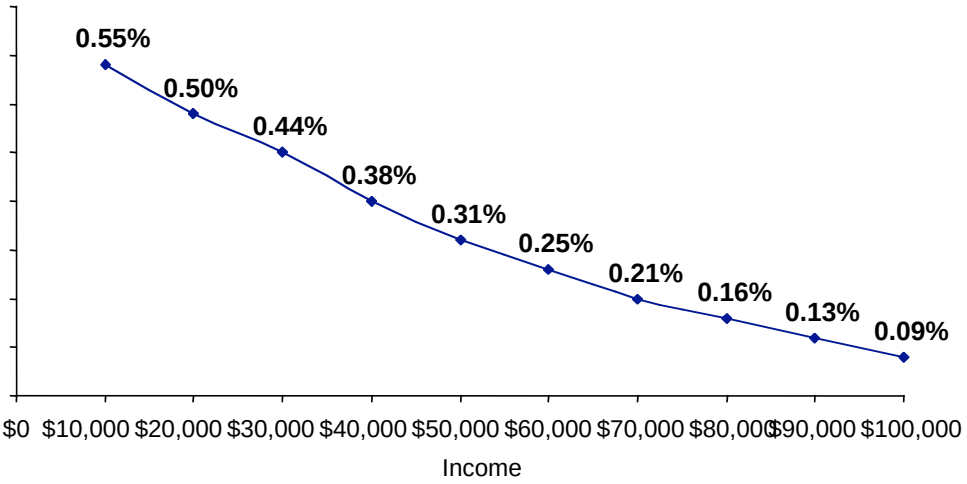
[2] This required imputing premiums based upon employer survey data developed by the Kaiser Family Foundation (KFF) and the Health Research and Education Trust.

percent real (i.e., inflation adjusted) reduction in private employer premiums would result in a 0.34 percentage increase in the number of people with insurance.[3]

We estimated price elasticity by age, income and other demographic characteristics. For example, the percentage increase in coverage resulting from a one percent reduction in premiums ranges from a high of 0.55 percent among people with incomes of $10,000 to 0.09 percent among people with incomes of $100,000 ***(Figure 1)*** (i.e. a price elasticity of –0.55 to –0.09). In addition, the percentage increase in coverage resulting from a one percent reduction in premiums ranges from 0.46 percent for people 20 years of age to 0.30 percent among people 60 years of age ***(Figure 2)*** (i.e. a price elasticity of –0.46 to –0.30). Thus, the model shows that older people and people in higher income groups are less sensitive to changes in price than other population groups.

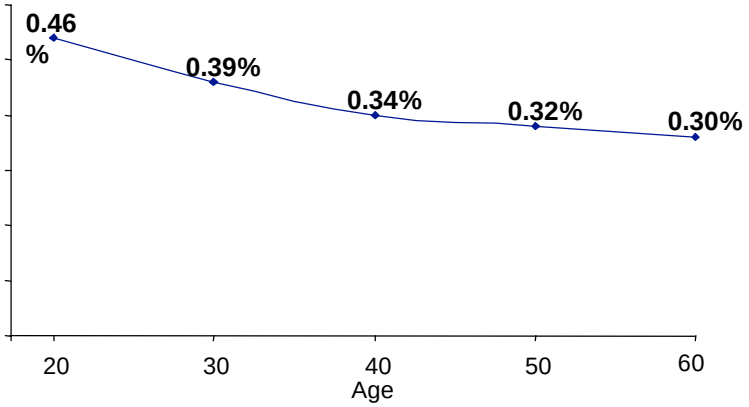
[3] See Sheils, J., Haught, R., "Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy", (report to The National Coalition on Health Care), The Lewin Group, October 18, 1999.

Figure 1
Percentage Change in Coverage Resulting from a One-Percent Reduction in Premiums by Income Level (in percentages) a/



a/ Indicates a price elasticity ranging between –0.55 to -0.09 by income.
Source: Lewin Group estimates.

Figure 2
Percentage Change in Coverage Resulting from a One-Percent Reduction in Premiums by Age (in percentages) a/



a/ Indicates a price elasticity ranging between –0.46 and –0.30 by age.
Source: Lewin Group estimates.

We used HBSM to simulate an individual's decisions to take coverage based on the analysis described above and the following assumptions:

- Up to 20 percent of uninsured workers are actually offered coverage through their job but have declined the coverage. Because the Proposal is designed to cover all workers with qualified coverage, we assumed that all workers in these firms take such coverage;

- We also assumed that people with non-group coverage would take employer coverage if offered;
- For non-workers, we assumed that they would switch to Health Care for America, based on the difference in price and price elasticity (described above);
- We assumed that Medicaid and SCHIP enrollees would also opt to take employer coverage when offered;
- We assumed that uninsured non-workers would purchase individual coverage based on the difference in price between an individual policy under current law and the premium required by Health Care for America;
- We assumed that all legal residents who are in a family that files taxes or had a family member with an inpatient hospital stay would purchase coverage or be automatically enrolled in Health Care for America; and
- If the costs of premiums less any subsidies exceed 9 percent of a family's income, we assumed that obtaining coverage is unaffordable and the individual would not take coverage. We estimated that the premium requirements in HCA relative to the enrollee's incomes were sufficiently low enough that no one failed to obtain coverage due to exceeding this affordability threshold.

Once we determined take up into Health Care for America, we then needed to assign individuals to the public HCA plan or an HMO-like private HCA plan. As stated earlier, the Proposal would offer a public HCA plan that is similar to Medicare fee-for-service. In addition it would offer a selection of HMO-like private health plans. To determine individuals' enrollment choices, we assumed that 70 percent of enrollees would choose the fee-for-service option and 30 percent would choose the HMO option. This is based on current HMO market penetration in the private market.

D. Employer Decision to Offer Coverage

We assumed that employers would choose between offering coverage and paying the 6 percent payroll tax based upon cost. Firms that find that the tax would be less than the cost of providing coverage would elect to pay the tax and cover their workers under Health Care for America. Firms that would find it less costly to provide employer-sponsored coverage would do so.

Generally, non-insuring firms would typically find that the cost of paying the payroll tax is less than the cost of providing coverage. This is because workers in these firms tend to have low wages resulting in a payroll tax payment that is less than the cost of insurance. Conversely, firms that now offer coverage have relatively higher wages that would result in payroll tax payments in excess of the cost of insurance. However, some non-insuring firms may start to offer coverage if this is less costly and some firms that now offer coverage may decide to discontinue their health plans and pay the tax to cover their workers under Health Care for America.

Using the synthetic firms database developed in HBSM, we determined the cost of Health Care for America and of private coverage to each employer in the following manner. First, we calculated the

Cost of private Insurance = Total Premium – Tax Exclusion
Cost of Health Care for America = Employee Premium + Payroll Tax

cost of private coverage as the total premium
(including both employer and worker's share) less the tax exclusion available to employers currently for health care benefits. Second, we determined the cost of Health Care for America as the sum of the worker's premium and the payroll tax. We assumed that the non-insuring firm would choose to offer private coverage or enroll their workers in Health Care for America based on the less expensive of the two alternatives.

For firms that currently offer coverage, we assumed that a firm would switch to Health Care for America depending on the difference between their private insurance costs currently, and the cost of enrolling workers in Health Care for America. First, we determined those costs using the same calculations described above for each firm in the HBSM synthetic firms database. We then determined the likelihood that the firm would switch from its current private plan coverage to Health Care for America based on the difference in the total premium cost from their current plan and the composite price elasticity based on the age and health status of their workforce.

Likelihood of switching from private coverage to Plan =

Percent change in cost x plan switching price elasticity (composite rate for all workers in firm).

E. Utilization of Health Services

We assumed that uninsured people who become covered under the Proposal would use health care services at the same rate reported by currently insured people with similar age, sex, income, and health status characteristics. This assumption encompasses two important effects. First, the increase in access to primary care for this population would result in savings due to a reduction in preventable emergency room visits and hospitalizations. Second, there would be a general increase in the use of elective services such as advanced diagnostic tests and other care that the uninsured either forgo or delay.

Some of the insured have policies that do not cover certain services such as prescription drugs (referred to as the *under*-insured). In this analysis, we assumed that utilization of these services by people who currently do not have coverage for these services would increase to the levels observed among insured people with similar demographic, income and health status characteristics.

F. Wage Effects

We assumed that changes in employer costs for health benefits are passed on to workers in the form of changes in wages. Thus, increases in employer costs are assumed to be passed on to workers in the form of reduced wages, while decreases in health benefits expenses are passed-back to workers in the form of wage increases. We assumed that this wage adjustment would occur among government employers as well, assuming that government compensation packages are adjusted to remain competitive in the labor markets. We assume that this pass-through occurs among both insuring and non-insuring firms whose labor costs are affected by the "pay-or-play" requirement.

Our pass-through assumption is based upon the economic principle that the total value of employee compensation, which includes wages, employer payroll taxes, health benefits and

other benefits, is determined in the labor markets. Although there is considerable agreement among economists that this pass-through would occur in response to changes in employer benefits costs, there is disagreement over the period of time over which these adjustments would occur. [4] It is likely that these adjustments would take the form of reduced wage growth over time. However, the full amount of the pass-through could take several years to materialize.[5] For our purposes, we assumed that the full impact of the wage effect is realized in the first year of program implementation.

G. Provider Payments

Provider payment levels for covered services for enrollees in the public HCA plan would be adjusted to Medicare levels. For those services provided to enrollees who were previously covered by Medicaid we assumed the following: hospital payment levels would be increased by 14 percent, and physician payment levels would be increased by 45 percent.[6] For services provided to public HCA plan enrollees who previously had private coverage, we assumed that hospital payment levels would decrease by 26 percent and physician payment levels would decrease by 17 percent. For all other public HCA plan enrollees and services, we assumed that providers would be paid at Medicare rates. We assumed that payments to private HCA plans would be equivalent to what would be paid to cover individuals through the public HCA plan.

H. Prescription Drug Purchasing

Under the public HCA plan, prescription drugs would be purchased using a system such as the Veteran's Administration drug purchasing approach to bargain for lower prices. [7] In addition, a drug formulary that favors the use of lower-cost drugs when possible and bargaining for volume discounts from durable goods manufacturers would further reduce prices.

In this analysis, we assumed that Health Care for America would negotiate discounts with drug manufacturers for all people covered under the public HCA plan that are equivalent to the discounts and rebates received by large HMOs. Under this assumption, savings would be about 35 percent for drugs used by people who do not currently have drug coverage and about 19 percent for people who currently have private drug coverage. There would be a small increase in costs for drugs purchased by the current Medicaid population reflecting the leveling of pharmacy payments across all payers (***Figure 3***).

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4 See, for example, James Heckman, "What Has Been Learned About Labor Supply in the Past Twenty years?" American Economic Review, (May 1993).

5 See, for example, Jonathan Gruber and Alan B. Kreuger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers Compensation Insurance," in Tax Policy and the Economy (1991); Jonathan Gruber, "The Incidence of Mandated Maternity Benefits, " American Economic Review, (forthcoming); and Lawrence H. Summers, "Some Simple Economics of Mandated Benefits, " American Economic Review (May 1989).

6 A Data Book: Healthcare spending and the Medicare program, MedPAC, June 2007; Report to the Congress: Medicare Payment Policy, MedPAC, March 2007; and www.statehealthfacts.org.

7 The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. Section 340B of the Public Health Service Act limits the cost of covered outpatient drugs to certain federal grantees, federally-qualified health center look-alikes and qualified disproportionate share hospitals.

Figure 3
Average DRUG Price from Manufacturer to Customer in 2000

	Cash Only Customers	Private Insurers and PBMs [a/]	Medicaid Enrollees	Large HMOs [b/]
Average Wholesale Price	$50	$50	$50	$50
Manufacturers Price to Wholesalers	$40 (AWP -20%)	$40 (AWP-20%)	$40 (AWP -20%)	$34 (AWP-33%)
Acquisition Price (Wholesalers to Pharmacy)	$41	$41	$41	n/a
Pharmacy to Customer	$52 (AWP+4%)	$46 (AWP-13%+$2.50)	$43 (AWP+$2.50)	n/a
Manufacturer Rebates	n/a	$42 (8 percent)	$33 (20 percent)	n/a
Ultimate Amount Paid by Purchaser	$52	$42	$33	$34
Assumed Savings Levels	-34.6%	-19.0%	+3.0%	--

a/ Includes private insurers and pharmacy benefit management (PBM) plans, except HMOs that buy directly from manufacturers.
b/ Includes HMOs that buy directly from manufacturers.
Source: "Prescription Drug Coverage, Spending, Utilization and Prices: Report to the President," Department of Health and Human Services (HHS), April 2000.

I. Medical Home Requirement

The Proposal requires the public HCA plan to implement a 'Medical Home' program for all enrollees. Offering enhanced benefits at no additional premium, beneficiaries must select a 'Medical Home' as an alternative to traditional fee-for-service. The primary care physician would coordinate all care and authorize specialty referrals. In addition, primary care physicians are responsible for hospital admissions and obtaining prior authorization for elective inpatient and outpatient procedures. For providing a medical home to beneficiaries, participating primary care physicians are paid traditional fee-for-service rates plus an additional per patient, per month fee for enrolled beneficiaries, which we assume to be $4 per enrollee per month.

Evidence exists showing that as the role of the primary care physician in the delivery of medical care increases, health outcomes improve and costs decline.[8] The experience in the Medicaid program of strengthening the role of the primary care physician has shown significant cost savings.[9] Primary care case management (PCCM) programs have been a central mechanism for supporting the primary care physician as the coordinator of medical care in Medicaid programs for many years.

To estimate the savings to the public HCA plan of implementing the 'Medical Home' alternative, we adjust the benefits costs for public HCA plan enrollees to reflect potential

8 Starfield, B. 2005. *Contribution of Primary Care to Health Systems and Health*. The Milbank Quarterly, Vol. 83, No. 3 2005 (p.-457-502).
9 E.T. Momany et al, "A Cost Analysis of the Iowa Medicaid Primary Care Case Management Program," *HSR: Health Services Research* 41:4, Part I (August 2006).

savings of PCCM. Momany *et al.* (2006) modeled the 1991 to 1998 experience of the Iowa Medicaid program with PCCM. In this program, Medicaid beneficiaries were required to either enroll in a managed care plan or a PCCM practice if one was available in their county. The authors compared costs net administration in each year of PCCM to an estimate of the cost of the program without PCCM. They showed annual savings to the program in each year starting at 1.5 percent and increasing to 9.8 percent in 1998. The average annual savings over the period of their estimates was 3.8 percent. We projected the savings to national health expenditures by excluding the 9.8 percent savings in the final year and used a Whittaker graduation technique to trend Momany's estimates.[10] We estimated an average annual savings of 4.5 percent assuming the program is fully implemented and all effects are realized in 2007. To incorporate a 4 dollar payment rate to physicians we reduced the savings by 8 percent each year. Based on these assumptions, we estimate the medical home model would reduce spending for enrollees by 4.1 percent.

J. Administration

The Proposal establishes a default enrollment system. All U.S. residents are assumed to be covered under a national insurance pool called Health Care for America. Workers and their families effectively opt out of this program if their employer decides to offer coverage. Those enrolled in HCA are automatically enrolled in a fee-for-service (FFS) insurance program modeled on Medicare called the public HCA plan. Enrollees would have the option of enrolling in private HMOs called private HCA plans. In addition, the program provides subsidies to low-income people for premiums and cost-sharing. This new administrative structure has significant implications for the cost of administering insurance. The assumptions that we used to estimate the cost of administration under this system are presented below:

Employers that offer coverage: For those firms that decide to offer insurance, we assume that the cost of administering coverage would be on average the same as in the current private health insurance market. ***Figure 4*** presents our assumption on the cost of administering private insurance as a percentage of covered services by firm size. In addition, employer-sponsored plans would have the added cost of reporting enrollment to the Health Care for America. We assume that this represents a 10 percent increase in general administrative costs (a subcomponent of insurer administration), which we also assume to vary with firm size as shown in ***Figure 4***. We estimate that addition function will increase costs for insuring employers by about $1.0 billion, which would represent a 0.2 percent increase in their overall health spending.

[10] London, D., *Graduation: The revision of Estimates*, Chapter 4. Actex Publication, Winsted, Connecticut.

Figure 4
Cost of Administering Health Insurance as a Percentage of Claims under the Health Care for Americans Act

Size of Group	Administrative Costs as Percent of Claims Costs		
	Current System	Cost of Reporting Enrollment	Total Cost
2 to 4	35.8%	1.5%	37.3%
5 to 9	31.1	1.3	32.4
10 to 19	26.5	1.1	27.6
20 to 49	21.8	0.9	22.7
50 to 99	15.3	0.6	15.9
100 to 499	13.5	0.5	14.0
500 to 2,499	10.4	0.5	10.9
2,500 to 9,999	6.7	0.2	6.9
10,000 or more	4.5	0.1	4.6
Total	12.7%	0.5%	13.2%

Source: Analysis of the effect of creating a mandatory insurance pool developed by the Hay Group, "Cost and Effects of Extending Health Insurance Coverage," Congressional Research Service 1990.

Non-insuring employers: Firms that decide not to offer coverage would face only minimal administrative costs related to the program. Although these employers would be required to pay a payroll tax, they would not need to report the names of workers and dependents in these firms to Health Care for America so that they can be covered. These people would automatically be covered under Health Care for America if they are not reported as covered under another employer's plan. The cost of administering the payroll tax payments in non-insuring firms would be minimal because it builds upon the Social Security withholding system.

Public HCA plan administration: The public HCA plan is a fee-for-service program modeled on the existing Medicare program. We assume that the cost of administering coverage would be the same as under the existing Medicare program, which we estimate to be about $115.77 per year for 2006, which is about 3 percent of the average cost per Medicare beneficiary (***Figure 5***). We adjusted these costs to reflect the cost of covering the public HCA plan population, resulting in an average cost of $82.33 per enrollee. These adjustments include:

- We adjusted the claims-processing and utilization-review costs to reflect the lower levels of service utilization per enrollee among the non-Medicare population. Other costs were reduced in the same proportion; and
- We assumed that claims-processing costs would increase by one-third to reflect the cost of coordinating benefits with the lists of people reported as covered under private health plans.

We estimate that administrative costs for public HCA plan enrollees would be about $7.4 billion, which is based on 90 million enrollees * $82.33 per year. These administrative costs would represent about 3 percent of paid claims for public HCA plan enrollees.

Figure 5
Derivation of FFS Insurer Administrative Costs Per-Enrollee
under the Public HCA Plan in 2006 [a/]

	Current Medicare Costs Per Enrollee in Existing Program	Estimated Costs for Non- Enrollees in FFS Program [b/]		
		FFS Administrative Costs	Coordination of Coverage	Total Costs
Claims Processing	$64.45	$38.67	$12.87	$51.54
Utilization Review	$29.13	$17.48	--	$17.48
Research/Demonstrations	$1.75	$1.05	--	$1.05
Agency Administration	$20.44	$12.26	--	$12.26
Total	$115.77	$69.46	$12.87	$82.33

a/ Insurer administrative costs were extrapolated from administrative costs for the current Medicare program, using data supplied by CMS.
b/ The number of health services used by the non-Medicare population is on average about 55 percent less than among the aged and disabled people covered under Medicare. We estimated this using the Medical Expenditures Panel Survey (MEPS) data for 1999 through 2001.
c/ Assumes administrative per-enrollee cost growth of 3.8 percent per year between 2003 and 2006 based upon the HCFA Implicit Medical Price Deflator estimated by the CMS Office of the Actuary.
Source: Lewin Group estimates.

Private HCA plan administration: We assume that the private HCA plans would have administrative costs similar to existing HMOs of about 12 percent. In addition, we assume that Health Care for America would incur the cost of administering enrollment for people who elect private HCA plans. We estimate these costs to be $30.76 per year, which is equal to the public HCA plan administrative costs per enrollee less claims processing and coordination of benefits costs. Based on these assumptions, we estimate that private HCA plan administration would be about $14.0 billion for about 39 million enrollees. The enrollment administration function performed by Health Care for America would be $1.2 billion in 2007.

Low-income assistance for premiums: The low-income subsidies for people enrolled in Health Care for America would be administered through the tax code. Under this program, people must pay as part of their taxes a premium for each month they were not covered outside of Health Care for America (Worker coverage would be reported on each worker's W-2 form). The premium would be adjusted to reflect the sliding-scale premium subsidy created under the proposal. We assume that the IRS administrative budget would be increased by 25 percent to administer these premium collections.

One concern with using the tax system to administer health coverage is that people with incomes below certain levels are not required to file tax returns. However, under this Proposal people who do not have enough income to be required to pay taxes are not required to pay

Health Care for America premiums anyway. Thus, low-income people would not need to make separate applications to enroll in Health Care for America.

Low-income cost-sharing subsidies: Under this program, Health Care for America enrollees with low incomes would be eligible for assistance in paying copayments and deductibles under the program. We assume that people who are found eligible under other income-tested programs such as Food Stamps or WIC would be automatically deemed eligible for reduced cost-sharing. Health Care for America would then automatically adjust provider payments for these to reflect the maximum cost-sharing amounts for the individual. (For example, the program would pay 100 percent of the allowed charge leaving nothing for the provider to collect in cost-sharing.)

Low-income individuals who are not eligible for other income-tested programs would be required to make a separate application to a Medicaid agency (Medicaid is retained for low-income Medicare enrollees) for assistance with copayments. Also, people who are eligible for Medicaid under current law would continue to be eligible for any Medicaid-covered services that are not covered under the Health Care for America benefits package. We assume that spending for processing income eligibility under Medicaid would continue at its current levels as a public expense under the proposal (income eligibility processing is estimated to be about $171 per family per year under the current Medicaid program).

K. Public Financing

Under the HCA Proposal, employers who do not offer coverage would be required to pay a 6 percent payroll tax to have their workers covered under Health Care for America. We assumed that the higher the tax rate, the more likely it is that employers would decide to offer or maintain private coverage as Health Care for America coverage becomes more expensive. We analyzed the impact that various payroll tax rates would have on changes in enrollment from current sources of coverage to Health Care for America, as well as on costs. For this sensitivity analysis we assumed payroll tax rates of 5 percent and 7 percent in comparison to the proposed 6 percent tax rate under Health Care for America. The effect of these tax rates on utilization, cost-shifting, administrative costs, and national health spending is presented in our results.

III. COST AND COVERAGE IMPACTS

We present the cost and coverage impacts of the Health Care for America Proposal in the following sections:

- Transitions in Coverage;
- Impact on National Health Spending;
- Impact on Health Spending by Stakeholder Group; and
- Cost and Coverage Impacts at Various Payroll Tax Rates

A. Transitions in Coverage

The Health Care for America Proposal would require that all U.S. residents (including non-citizens) have health care coverage. The Proposal would create a new national insurance pool modeled after Medicare. All current beneficiaries of Medicaid and the State Children's Health Insurance Program (SCHIP) would be transferred to Health Care for America. It would also provide access to coverage for people who are not working and those who are self-employed.

Health Care for America would include benefits in the current Medicare program, as well as mental, maternal and child health services, and comprehensive prescription drug coverage. It would offer a Medicare-like fee-for-service plan and a selection of Health Maintenance Organizations or other managed private plans. Premiums and copayments for services would be charged, with the exception of preventive care. Low-income people would receive premium subsidies and their copayment levels would be capped on a sliding scale, based on income. We present the changes in coverage in ***Figure 6.***

Figure 6
Transitions in Coverage under Health Care for America Proposal in 2007 (millions)

		Health Care for America Plan		Private Coverage			Public Coverage			
Coverage Under Current Law		Covered Through Employer	Covered as Individual	Employer	Non-Group	Employer-Retiree	CHAMPUS/ Other	Medicare (incl. dual eligibles)	Medicaid/ SCHIP	Uninsured
Employer [a/]	153.7	51.8	0.0	101.9	0.0	0.0	0.0	0.0	0.0	0.0
Non-Group [b/]	9.5	4.0	2.6	2.7	0.2	0.0	0.0	0.0	0.0	0.0
CHAMPUS/Other	3.4	0.0	0.0	0.0	0.0	0.0	3.4	0.0	0.0	0.0
Medicare (incl. dual eligibles)	39.9	0.0	0.0	0.0	0.0	0.0	0.0	39.9	0.0	0.0
Medicaid/SCHIP [c/]	37.5	9.1	24.4	4.0	0.0	0.0	0.0	0.0	0.0	0.0
Employer-Retiree	3.3	0.6	0.0	0.8	0.0	1.9	0.0	0.0	0.0	0.0
Uninsured [d/]	47.8	19.7	16.4	10.3	0.0	0.0	0.0	0.0	0.0	1.3
Total	295.1	85.2	43.4	120.1	0.2	1.9	3.4	39.9	0.0	1.3

a/ Assumes employer switch to Health Care for America Plan based on the difference in total premium cost from their current plan and the composite price elasticity based on the age and health status of their workforce.
b/ Assumes people with non-group coverage take employer coverage if offered. For non-workers we assume they switch to Health Care for America plan based on difference in price and a price elasticity based on age and health status.
c/ Assumes Medicaid and SCHIP enrollees take employer coverage if offered.
d/ Assumes all uninsured people take employer coverage if offered. Assumes uninsured non-workers purchase individual coverage based on difference in price from an individual policy under current law. Due to the proposal coverage requirement, we assume all legal residents who are in a family that files taxes purchases coverage. However, if premium costs after subsidies exceed 9% of income then we assume it is unaffordable and they do not purchase coverage.
Source: The Lewin Group estimates using the Health Benefits Simulation Model.

We estimate that there are currently 153.7 million people covered through their employer. We estimate that under the Proposal 101.9 million would remain covered through their employer-sponsored plan. About 51.8 million would switch to Health Care for America coverage. Based on our analysis of how employers react to price changes, employers who find that paying the payroll tax is less expensive than providing private coverage would drop their private coverage and their workers would be covered under Health Care for America. These are likely firms with low-wage workers resulting in a payroll tax payment that is less costly than offering private coverage.

Few of the 9.5 million people currently in non-group coverage would maintain such coverage reflecting the better terms of HCA coverage. We estimate that only 200,000 people would retain their current private non-group insurance. About 2.7 million people would move to employer coverage. As mentioned earlier, employers would decide to provide coverage or pay the payroll tax to enroll their workers in Health Care for America based on the price difference. As such, 2.7 million people would be covered under their employer-sponsored coverage and 4 million would be covered by their employer through Health Care for America. Finally, 2.6 million

people would purchase individual coverage or be automatically enrolled in Health Care for America. This includes individuals who would receive a subsidy as well as those who would not receive a subsidy.

Some individuals currently covered through Medicaid and SCHIP would take employer coverage if offered. We estimate that there would be 4 million individuals who would take private employer coverage. The remaining individuals would be covered under Health Care for America, either as individuals or by virtue of their employer paying the payroll tax. We estimate that 9.1 million people would be covered under Health Care for America through their employer and 24.4 million would be covered as individuals.

There would be no change to the number of people who are currently covered through Medicare, including those who are eligible for both Medicaid and Medicare (i.e., dual eligibles), or in TRICARE/CHAMPUS, which is the health insurance program for military personnel. Out of 3.3 million people getting retiree coverage through an employer, 600,000 would become covered through the Plan as employers decide to move to the least expensive alternative. The remaining 2.7 million would remain in private coverage. Overall, the plan would reduce the number of uninsured by about 97.3 percent, leaving 1.3 million people uninsured.

B. Impact on National Health Spending

The U.S. currently spends $2.26 trillion on health care.[11] This includes spending for all health services by all payers including Medicare, Medicaid, ESI, non-group insurances, worker's compensation and various safety net programs. Spending includes payments for services, and the cost of administering both public and private health insurance coverage. ***Figure 7*** presents our estimates of the changes in health spending under the Health Care for America Proposal.

We assumed that utilization of health services would increase for newly insured people to the levels reported by insured people with similar demographic and health status characteristics. We estimate that this would result in a net increase in utilization for the newly insured of $49.8 billion in 2007. In addition, some people who currently have coverage (e.g., employer-sponsored coverage) would move to Health Care for America, which may result in more comprehensive coverage, and in increased utilization for those newly covered services. We estimate that this increase in utilization for currently insured people would result in an increase in spending of about $3.4 billion. We estimate that the total increase in national health spending due to increased utilization would be about $53.2 billion in 2007.

The Proposal would result in a net reduction in spending of $7.4 billion attributable to various reimbursement effects. This includes a $16.7 billion increase in provider payments for previously uncompensated care and a $29 billion reduction in provider payment levels because Health Care for America would reimburse providers at Medicare levels. Under the current system, uncompensated care from services to the uninsured as well as the reduced provider payment levels is shifted to private payers in the form of higher charges in a process known as cost shifting. Under the Proposal, the increase in payments for previously uncompensated care is passed on as lower charges to providers; however, this is not sufficiently offset by the

[11] Centers for Medicare and Medicaid Services, Office of the Actuary, 2007 National Health Expenditures projections.

increase in charges to private payers resulting from the lower payment rates. Based on the literature on cost shifting, we assume that about 40 percent of the reduction in provider payments is passed on to private payers in the form of higher negotiated payment rates, thereby increasing cost shifting by $4.9 billion.

The public HCA plan would adopt drug negotiation practices for their enrollees, which include negotiated discounts and the use of strict formularies to levels. We assume that this program would achieve savings similar to current large HMOs. We estimate that this would reduce prescription costs by 19 percent for enrollees from private insurers and 35 percent for previously uninsured enrollees, totaling $8.8 billion reduction in prescription drug spending. In addition, Health Care for America would require enrollees electing the public HCA plan to have a Medical Home. We estimate that this would result in a 4.1 percent net reduction in utilization for these enrollees, or $11.7 billion.

Finally, we estimate that the cost of administration in the health care sector would decrease by about $25.4 billion. This includes a reduction in insurer administration of $29.9 billion as people become covered under the HCA Proposal, and an increase of $4.5 billion to administer subsidies for the low-income people.

Figure 7
Changes in National Health Spending under Health Care for America Proposal in 2007
(billions)

Change in Health Services Expenditures		$53.2
Change in utilization for newly insured	$49.8	
Change in utilization for currently insured	$3.4	
Reimbursement Effects		($7.4)
Payments for previously uncompensated care	$16.7	
Change in Provider Payment Levels [a/]	($29.0)	
Increased Cost Shifting [b/]	$4.9	
Negotiated Drug Discounts and Medical Home Requirement		($20.5)
Reduced Spending on Drugs due to Negotiated Discounts [c/]	($8.8)	
Medical Home Requirement [d/]	($11.7)	
Change in Administrative Cost of Programs and Insurance		($25.4)
Change in Insurer Administration	($29.9)	
Eligibility Determination for Subsidies and Premium Collections [e/]	$4.5	
Total Change in National Health Spending		($0.1)

a/ Assumes provider payment levels in Health Care for America Plan are based on Medicare payment rates. Payments were increased for enrollees previously covered by Medicaid by 14% for hospital services and 45% for physician services. Payment rates were reduced for enrollees previously covered under private insurance by 26% for hospitals services and 17% for physician services.
b/ Assumes 40 percent of change in provider payment rates are passed on to private health plans in the form of lower negotiated rates.
c/ Assumes the Health Care for America Plan will reduce prices for prescription drugs through negotiated drug discounts and strict formularies to levels similar to current large HMOs. We estimate this will reduce Rx costs by 19% for enrollees from private insurers and 35% for previously uninsured enrollees.
d/ All public HCA plan enrollees are required to have a Medical Home. We estimate a net 4.1% reduction in utilization for these enrollees.
e/ Assumes subsidies administered through federal income tax system and IRS budget increased by 25%.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 8 shows our estimates of the revenues and costs under the Health Care for America Proposal assuming it is fully implemented in 2007. We estimate the total cost of the program to be $417.7 billion, including benefits and administration. We estimate that benefits provided to people who enroll through their employer would cost about $214.7 billion. We estimate that benefit costs for Medicaid disabled enrollees would be about $67.3 billion and about $108.6 billion for the remaining enrollees. Finally, program administration would cost about $22.6 billion, eligibility determination for low cost subsidies would cost $2.3 billion and premium collections costs would be about $2.2 billion bringing the total administrative costs of the program to approximately $27.1 billion.

Health Care for America would be financed through premiums and the 6 percent payroll tax on employers. Employers who find the cost of the payroll tax cheaper than providing private coverage would opt to pay the tax. This would generate about $91.9 billion in revenue for the

Plan. Employee premiums would generate about $49.3 billion in revenues and the premiums, net of subsidies, from those who enroll privately in Health Care for America would bring in about $31 billion. People below the federal poverty level are not required to pay any premiums and premiums are phased in through 400 percent of the FPL.

Employers are required to pay a tax or provide private coverage. Under this "pay-or-play" requirement we assume that employers of workers who are covered as dependents under Health Care for America would be required to transfer the 6 percent payroll tax to Health Care for America. We estimate that this would generate about 14.9 billion in payment transfer from employers. The total revenue from premiums and payroll tax collections is about $187.1 billion, which results in net program costs of $230.6 billion.

Figure 8
Health Care for America Costs and Revenues
(Assumes program fully implemented in 2007)

Health Care for America - Program Costs (billions)		$417.7
Benefit Costs	$214.7	
Covered Through Employer	$67.3	
Covered as Individual (Medicaid Disabled)	$108.6	
Covered as Individual (Other)	$27.1	
Administrative Costs [a/]		
Health Care for America - Program Revenues (billions)		$187.1
Employer Premiums (6% payroll)	$91.9	
Employee Premiums	$49.3	
Individual Premiums [b/]	$31.0	
Employer Transfer Premiums [c/]	$14.9	
Net Program Costs/(Savings) (billions)		$230.6

a/ Includes administration of program ($22.6) and eligibility determination for low-income subsidies ($2.3 billion) and premium collections ($2.2 billion).
b/ Based on community-rated premiums in the program net of subsidies. There are no premiums for people below poverty and premiums are phased in through 400% of FPL.
c/ Assumes employers of workers who are covered as a dependent on the spouse's Health Care for America Plan, pay 6% of worker's payroll to Health Care for America Plan.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

C. Impact On Health Spending By Stakeholder Groups

We present our estimates of the impact of the Health Care for America Proposal on governments, private employers, and households, in the following sections:

- Changes in Health Spending by Stakeholder Group *with* and *without* Wage Effects;
- Impact on Federal Government Health Spending;
- Impact on State and Local Government Health Spending;
- Impact on Private Employer Health Spending; and

- Impact on Family Health Spending

1. Changes in Health Spending by Stakeholder Group

Under the Proposal, all U.S. residents (including non-citizens) would be required to have coverage. In addition, employers would be required to provide private coverage or pay a 6 percent payroll tax. ***Figure 9*** shows the change in health spending under the Proposal for governments, private employers and households. Under the Proposal, a national health insurance pool similar to Medicare is created resulting in a $53.4 billion increase in health care spending for the federal government. We assume that savings to employers are passed on to workers in the form of higher wages, which would be subject to federal income and payroll taxes. This additional tax revenue brings the overall increase in federal health spending under the Proposal to $49.3 billion.

The state and local governments save $26.9 billion as people previously covered under state and local government programs shift to Health Care for America. In addition, state governments no longer have to spend as much on safety net programs as more people become covered by insurance. Furthermore, state and local governments also provide health benefits to government workers, and their health care costs would be reduced under the Proposal. As a result, states and local governments would save about $26.9 billion. Reductions in employer costs would be passed on to workers in the form of wage increases and these increased wages will be subject to state income taxes where applicable. Thus, some of the savings to state and local government health benefits programs are passed on to workers; at the same time, additional state tax revenue is generated under the proposal. Accounting for both aspects of this wage effect, we estimate that the net savings to the state and local governments is about $21.2 billion.

Private employers would save about $10 billion in the aggregate as they decide to cover workers under the Proposal by paying the tax. Some of these savings would be passed on to workers in the form of higher wages resulting in a net savings to private employers of about $4.9 billion.

Households also save overall about $16.6 billion, as people under the poverty level are not required to pay a premium and the Proposal provides a sliding scale subsidy for up to 400 percent of the FPL. As mentioned earlier, households also receive increased wages as a result of lower health benefits costs for employers. This results in an overall savings of about $23.3 billion to households. Overall, we estimate that the Proposal would result in a $100 million reduction in spending for governments, private employers and households, after taking into account the wage impact.

Figure 9
Change in Health Spending by Stakeholder Group under the Health Care for America Proposal in 2007 (billions)

	Without Wage Effects	With Wage Effects
Federal Government	$53.4	$49.3
State and Local Government	($26.9)	($21.2)
Private Employers	($10.0)	($4.9)
Households	($16.6)	($23.3)
Total Health Spending	($0.1)	($0.1)

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

2. Impact on Federal Government Health Spending

In ***Figure 10***, we present our estimates of the change in spending for the federal government under the Proposal. Overall the Proposal's costs to the federal government would be about $230.6 billion. The federal government would spend $3 billion more as more workers take coverage under the federal employee health benefits program because of the mandate. The reduced cost to the federal government is passed on to workers in the form of higher wages. In addition, the federal government saves about $800 million in the costs of coverage for early retirees who would move to Health Care for America.

As Medicaid and SCHIP-eligible members are moved into Health Care for America, the federal share of spending for these programs would be reduced by $91.3 billion. However, the Proposal requires that states maintain their current levels of spending for these programs. We treat this as a reduction in federal government spending and estimate this to be about $68.8 billion. In addition, employers who provide coverage to people who are covered through Medicare and TRICARE/CHAMPUS (i.e., military personnel) are required to make transfer payments of the payroll tax attributable to these individuals to Health Care for America. We estimate these transfer payments to be about $7 billion. Finally, individuals who enroll in Health Care for America from the employer's private plan would no longer benefit from the tax exclusion that Section 125 plans offer. This would increase their taxes, which we present as a reduction in federal government health spending of $13.4 billion. Overall, the federal government would spend $49.3 billion more on health care as the costs of the program exceed the revenues and offsets.

Figure 10
Change in Federal Government Spending Under Health Care for America Proposal in 2007
(billions)

		Change in Spending
Federal Program Costs of Health Care for America		
Net federal costs for Health Care for America		$230.6
Federal Program Offsets		
Federal Employee Health Benefits		($0.8)
Workers and Dependents	$3.0	
Early Retirees	($0.8)	
Wage Effects [a/]	($3.0)	
Medicaid and SCHIP Programs		($160.1)
Federal Share of Reduced Medicaid and SCHIP Spending	($91.3)	
State Maintenance of Effort	($68.8)	
Employer Transfers for Working Medicare and CHAMPUS Beneficiaries [b/]		($7.0)
Tax Revenue Gain Due to Tax Effects [c/]		($13.4)
Elimination of Section 125 Plan Tax Exclusion for Workers who enroll in Health Care for America	($12.3)	
Wage Effects	($1.1)	
Total Federal Program Revenues and Offsets		($181.3)
Net Cost/(Savings) to Federal Government		$49.3

a/ Assumes reduced employer costs are passed on to workers in the form of higher wage increases.
b/ Employers pay 6% payroll tax for working Medicare and CHAMPUS beneficiaries who opt out of Health Care for America.
c/ Increase in tax revenue is counted as a reduction in federal government health spending.
Source: The Lewin Group estimates using the Health Benefits Simulation Model.

3. *Impact on State and Local Government Health Spending*

Figure 11 presents our estimates of the impacts of the Proposal on state and local government health spending. Some workers and dependents currently covered through state and local government health benefits would become covered through Health Care for America. We estimate this would result in savings to the state and local governments of about $5.8 billion for workers and their dependents and $2.2 billion for early retirees. Some of these savings would be passed on to workers in the form of increased wages totaling $5.8 billion in spending to the state and local government employers. This results in a net savings of $2.2 billion, after the wage effect.

Medicaid and SCHIP beneficiaries would be transferred to Health Care for America; however, these programs would continue to offer wrap-around coverage, coverage for Medicare/Medicaid dual eligibiles, and long-term care. These programs are funded in part by the state governments and the transition in coverage of Medicaid and SCHIP beneficiaries to Health Care for America would result in a savings of $68.8 billion to the state government. However, under the Proposal, states are required to maintain their current level of spending for health benefits so these savings would be passed on to the federal government to help fund Health Care for America.

Many uninsured people tend to access care through a safety net of publicly funded clinics and hospitals. As more people become covered, much of the care that is currently paid through safety net programs will become privately covered through insurance. Thus the state and local governments would see savings in safety net programs, which we estimate to be about $17.7 billion.

Currently, some employers allow their workers to pay their health benefits contributions (e.g., premiums and copays) with pre-tax dollars under what are known as "Section 125 plans." Under the Plan, this tax exclusion is eliminated for all workers who enroll in Health Care for America thus resulting in an increase in wages for the workers which means an increase in tax revenue. This is reflected as savings to the state and local government of $1.2 billion. We estimate that the net savings to states and local governments after wage effects from the tax exclusion would be about $1.3 billion. Overall, we estimate that state and local governments would save about $21.2 billion under the Health Care for America Proposal.

Figure 11
Change in State and Local Government Spending Under Health Care for America Proposal in 2007
(billions)

		Change in Spending
State and Local Government Employee Health Benefits		($2.2)
Workers and Dependents	($5.8)	
Early Retirees	($2.2)	
Wage Effects [a/]	$5.8	
Medicaid and SCHIP Programs		$0.0
State Share of Reduced Medicaid and SCHIP Spending	($68.8)	
Maintenance of Effort Payment to Federal Government	$68.8	
Savings to Other Health Safety Net Programs		($17.7)
Tax Revenue Loss Due to Wage Effects [b/]		($1.3)
Elimination of Section 125 Plan Tax Exclusion for Workers who enroll in Health Care for America	($1.2)	
Wage Effects	($0.1)	
Net Cost/(Savings) to State and Local Governments		($21.2)

a/ Assumes reduced employer costs are passed on to workers in the form of higher wage increases.
b/ Reduction in tax revenue is counted as an increase in State and Local Government health spending.
Source: The Lewin Group estimates using the Health Benefits Simulation Model.

4. Impact on Private Employer Health Spending

Figure 12 shows our estimate of the impact of the Proposal on health spending for private employers. We also present the effects of the Proposal on employers who currently offer coverage and those who do not. Private employers currently spend $442.7 billion on health care benefits. This includes $407.5 billion of health care spending on workers and dependents and $35.2 billion more on retirees. Under the Proposal, we estimate that private employers who currently offer coverage would save about $65.6 billion, while firms that do not currently offer coverage would see increased costs of $55.6 billion.

Under the Proposal, workers would be allowed to opt out of their employer-sponsored coverage only if they have alternative coverage. If the alternative coverage is through another employer, then the employers can arrange transfer payment, which we assume they all do. If the alternative coverage is through Health Care for America, Medicare or CHAMPUS, then we assume the employers pay the 6 percent payroll tax for the federal government. We estimate that total transfer payment would be about $47.8 billion for private employers. Also, for employers who would receive payments, it would reduce their health spending by $26.5 billion.

Currently many employers have Section 125 plans which allow workers to use pretax dollars to pay their share of their health benefit plan premium. The ability to pay health insurance premiums on a pre-tax basis provides a significant cost savings, making coverage more affordable and encouraging the individual to enroll in health insurance. Under the HCA Proposal, individuals would lose this tax exclusion if they enroll in Health Care for America. This results in an increase in their taxable wages which, in turn, results in an increase in the employer's payroll taxes of $2.8 billion.

Figure 12
Changes in Private Employer Health Spending Under Health Care for America in 2007

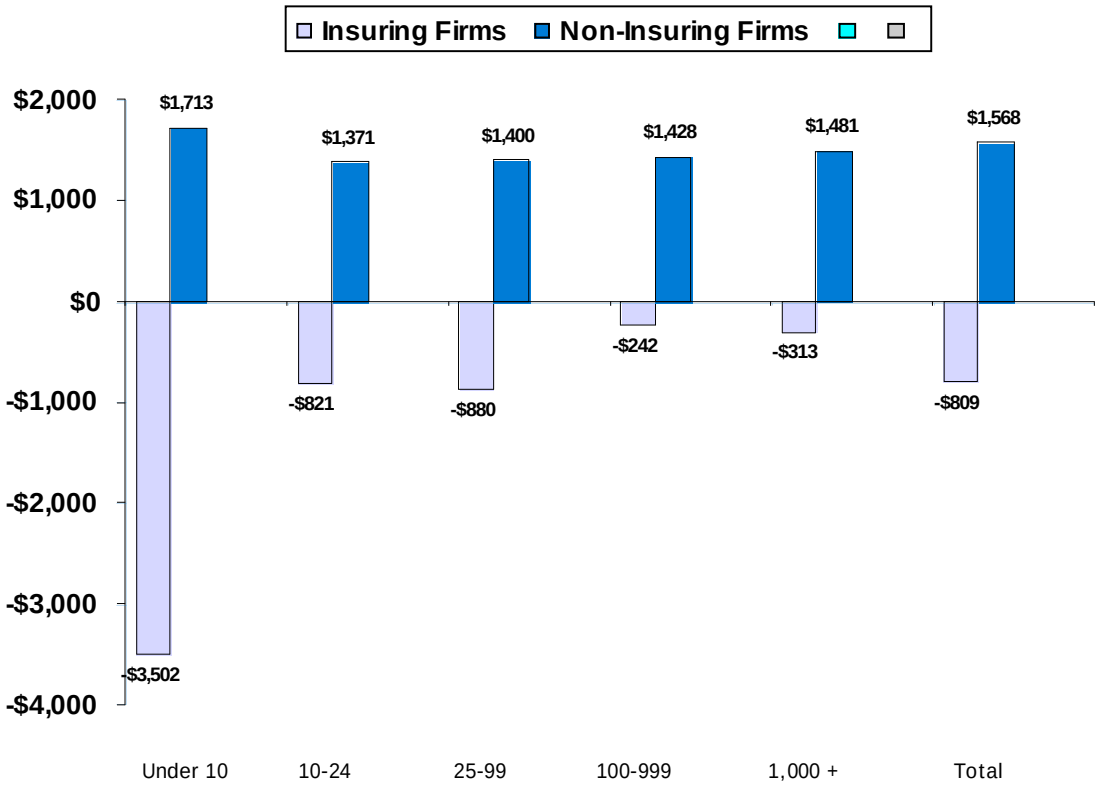
	Currently Insuring Employers	Currently Non-Insuring Employers	All Employers
Private Employer Spending Under Current Law (billions)			
Current			
Workers & Dependents	$407.5	--	$407.5
Retirees	$35.2	--	$35.2
Total	$442.7	--	$442.7
Private Employer Spending Under the Health Care for America Plan (billions)			
Workers and Dependents in firms that continue to offer coverage	$289.4	$8.4	$297.7
Continued Retiree Coverage	$30.3	--	$30.3
Health Care for America Premiums (6% payroll)	$54.6	$23.2	$77.8
Increased Cost Shifting	$2.7	--	$2.7
Transfer Payments Made [a/]	$22.6	$25.2	$47.8
Transfer Payments Received [b/]	($25.3)	($1.2)	($26.5)
Increased Payroll Taxes [c/]	$2.8	--	$2.8
Total	$377.1	$55.6	$432.7
Net Change (before wage effects)	($65.6)	$55.6	($10.0)

a/ Transfer payments are made by employers for workers who opt out of employer coverage due to coverage from another source.
b/ Employers that offer private coverage may receive transfer payments from another employer for their workers taking coverage as dependents on the spouse's plan.
c/ Employers will be responsible for their share of increased payroll taxes due to elimination of Section 125 plan tax exclusion for workers enrolled in Health Care for America Plan.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Overall, private employers would save $10 billion in health care spending of which $65.6 billion is savings to those employers who currently offer coverage. Those who do not currently offer

coverage would spend $55.6 billion more on health care. As illustrated in ***Figure 13***, non-insuring firms spend more on average regardless of the size of the firm. Those with ten or fewer workers would spend about $1,713 more per worker, and those with one thousand workers or more would spend about $1,481 more per worker. On average these firms would spend $1,568 more per worker. Firms that currently provide coverage experience savings regardless of the firm size. However, the smaller firms save more per worker. Firms with 10 or fewer workers would save $3,502 per worker compared to the average savings across all firm sizes of $809 per worker.

Figure 13
Change in Private Employer Health Spending Per Worker by Current Insuring Status Under Health Care for America in 2007 (by firm size)



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

5. *Impact on Family Health Spending*

Overall, people would experience savings under the Health Care for America Proposal ***(Figure 14)***. Looking just at premiums and subsidies for coverage, people would see an increase in premiums net of subsidies of about $1.5 billion. Workers below 200 percent of the federal poverty level (FPL) and non-workers below the federal poverty level, who enroll in Health Care for America, would not pay premiums. Health Care for America premiums would be required on a sliding scale for workers up to 300 percent of FPL and non-workers up to 400 percent of the FPL.

Families would see savings in out-of-pocket spending for health care of about $28.8 billion since nearly all people would be covered under the Proposal. Also, those enrolled in Health Care for America would have limits on their out-of-pocket spending that would prevent it from exceeding a percentage of their family income.

Families would see an increase in health spending of $10.7 billion as the Proposal eliminates the benefit of being able to pay their premiums on a pre-tax basis under Section 125 plans. As discussed earlier, employers overall save about $10 billion. Some of these savings are passed on to workers in the form of higher wages, which we reflect as savings in family health spending of about $6.7 billion.

Overall, then, families would save $23.3 billion, after taking into account the wage effect.

Figure 14
Impact of Health Care for America Proposal on Family Health Spending in 2007 (billions)

	Change in Spending Before Wage Effects	Change in Spending After Wage Effects
Change in Premiums	$1.5	$1.5
Change in Out-of-pocket Payments	($28.8)	($28.8)
Elimination of Section 125 Plan Tax Exclusion for Workers who enroll in Health Care for America	$10.7	$10.7
After Tax Wage Effects [a/]	n/a	($6.7)
Net Change	($16.6)	($23.3)

a/ The increase in after-tax wage income resulting from reduced costs to employers is counted here as a reduction in family health spending.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

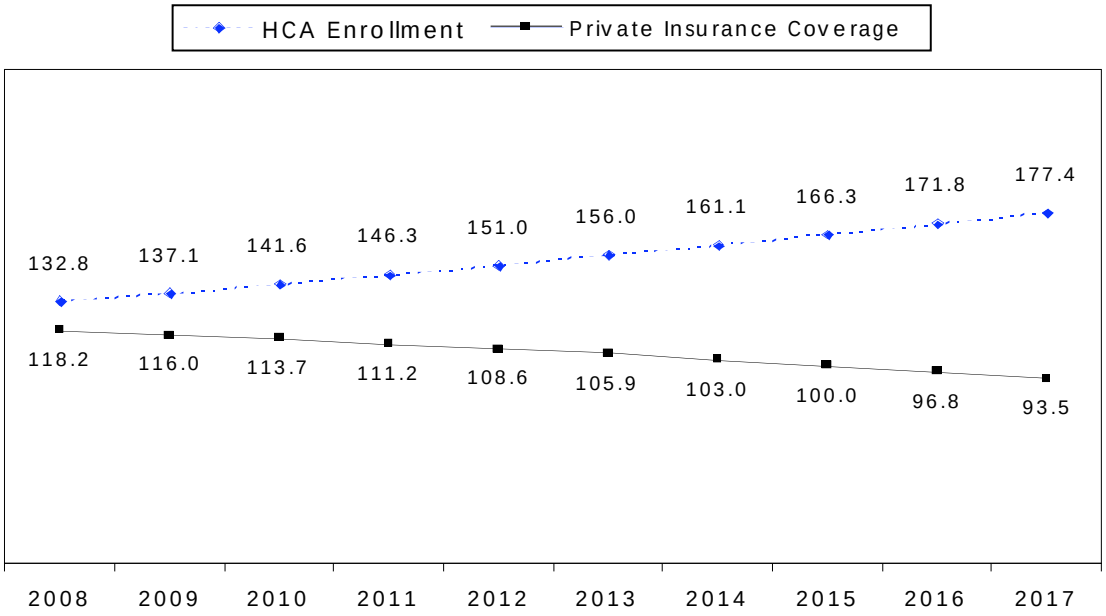
D. Projected Enrollment and Costs 2008-2017

Health Care for America will restrict the rate of growth in health spending in the public and private HCA plans by controlling the updates to hospital, physician and health plan payment rates and negotiating deeper discounts for prescription drugs. The Proposal specifies annual health spending per enrollee in Health Care for America to increase at the rate of the growth in Gross Domestic Product (GDP) plus ½ percent. Between 2008 and 2017 the estimated growth in the GDP plus ½ percent is 5.3 percent per year compared to projected health spending growth of 6.9 percent per year. Thus, spending and premiums in the HCA pool would be constrained to grow at 1.6 percentage points per year less than spending in the private insurance market.

As described above, we estimated that average spending per enrollee in Health Care for America would be about 23 percent lower than comparable private health insurance in 2007 due to lower provider payment rates and a simplified administrative structure. Therefore, by 2017 average spending per enrollee in Health Care for America could be 35 percent lower than private insurance due to the slower growth rate. The slower rate of growth would make Health Care for America a more attractive option to employers and individuals over time and market

share will increase in the future. ***Figure 15*** shows projected enrollment in Health Care for America compared to the private insurance market from 2008 to 2017.

Figure 15
Number of Health Care for America Enrollees and Private Insurance Coverage 2008-2017
(millions)



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

The combined effect of increased market share and a constrained rate of growth in Health Care for America spending would result in pressure on providers to shift costs to the private insurance market, which will increase private insurance premiums and generate an even larger difference in premiums between HCA and the private insurance market. We also estimate that the increased market share and a constrained rate of growth in HCA will reduce national health spending by about $1.0 trillion during the 2008 through 2017 time period (***Figure 16***).

Figure 16
Change in National Health Spending Under the Health Care for America Proposal
2008-2017 (billions)

Year	National Health Spending Under Current Law	Health Care for America Spending	All Other Health Spending	Total Health Spending Under the Proposal	Change in National Health Spending
2008	$2,420.0	$448.8	$1,958.3	$2,407.1	-$12.9
2009	$2,596.0	$482.1	$2,085.0	$2,567.2	-$28.8
2010	$2,776.4	$518.0	$2,213.2	$2,731.2	-$45.2
2011	$2,966.4	$556.5	$2,347.0	$2,903.5	-$62.9
2012	$3,173.4	$597.9	$2,491.9	$3,089.9	-$83.5
2013	$3,395.8	$642.4	$2,646.6	$3,289.0	-$106.8
2014	$3,628.6	$690.2	$2,806.9	$3,497.1	-$131.5
2015	$3,874.6	$741.5	$2,974.8	$3,716.3	-$158.3
2016	$4,136.9	$796.7	$3,152.4	$3,949.0	-$187.9
2017	$4,418.2	$855.9	$3,341.5	$4,197.4	-$220.8
2008-2017	$33,386.3	$6,330.0	$26,017.6	$32,347.6	-$1,038.7

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

The Proposal specifies that the payroll tax rate for employers to buy into Health Care for America and the premiums charged to workers and non-workers would be indexed to keep pace with the growth in program spending. Although the premium revenues would never be sufficient to cover the entire cost of the program, by design they will keep pace as a percentage of program costs (***Figure 17***). Savings to the federal share of the Medicaid and SCHIP programs from shifting Medicaid recipients into Health Care for America as well as offsets to other health programs will cover an increasingly larger share of the Health Care for America shortfall over time. This is because the estimate of what these programs would have cost is projected to grow faster than what it costs to cover these people under Health Care for America. For example, spending for Medicaid recipients was projected to grow at an annual rate of 7.3 percent assuming these people stayed in Medicaid and this projected cost is used to fund Health Care for America.

The Proposal specifies that the states' share of Medicaid and SCHIP programs are returned to the federal government through maintenance of effort payments. We assume that the maintenance of effort amount will be determined for each state in the initial year of the Proposal. States will be required to submit these payments to the federal government every year and the amount of the maintenance of effort payments in future years will be equal to the base amount inflated by the proposed HCA spending growth for that year, which is tied to the growth in GDP plus ½ percent.

We estimate that the net federal cost of the Health Care for America proposal would be about $534 billion over a ten-year period, 2008-2017.

Figure 17
Change in Federal Government Health Spending Under the Health Care for America Proposal 2008-2017 (billions)

Year	Health Care for America Spending	Health Care for America Revenues	Other Health Program Offsets [a/]	Net Federal Cost
2008	$448.8	$203.6	$194.0	$51.2
2009	$482.1	$221.6	$207.7	$52.8
2010	$518.0	$241.2	$222.5	$54.3
2011	$556.5	$262.6	$238.7	$55.2
2012	$597.9	$286.0	$256.2	$55.7
2013	$642.4	$311.5	$275.3	$55.6
2014	$690.2	$339.4	$295.8	$55.0
2015	$741.5	$369.8	$318.0	$53.7
2016	$796.7	$403.0	$341.9	$51.8
2017	$855.9	$439.2	$367.8	$48.9
2008-2017	$6,330.0	$3,077.8	$2,718.0	$534.2

a/ Assumes that federal Medicaid and SCHIP savings is used to fund Health Care for America and these savings are indexed to the growth in Medicaid and SCHIP spending as projected by CMS. State maintenance of effort payments are indexed to the proposed growth in the HCA program (GDP + ½%).
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

States will be required to submit maintenance of effort payments to the federal government every year and the amount of the payments in future years will be equal to the base amount inflated by the proposed HCA spending growth. Thus, over time, states will realize savings from what they would have spent on Medicaid and SCHIP because the projected growth rate in those programs is higher than the proposed HCA growth rate (***Figure 18***).

We estimate that savings to private employers will increase over time as well. Employers that cover their employees through HCA will see lower premium increases (via the payroll tax) than what they would have paid in the private market. Also, more and more employers will cover their workers under HCA over time as the payroll tax will become an increasingly better deal because the rate of increase in wages and the payroll tax rate will be less than the projected increases in private insurance premiums.

Finally, households will also see increased savings over time due to the slower rate of growth in HCA premiums as compared to premium increases in the private market and as an increasing proportion of workers are enrolled in HCA by the employers.

Figure 18
Change in Health Spending Under the Health Care for America Proposal by Stakeholder 2008-2017 (billions) [a/]

Year	State and Local Governments	Private Employers	Households
2008	-$30.5	-$18.2	-$17.8
2009	-$34.6	-$27.4	-$22.3
2010	-$39.1	-$36.8	-$26.3
2011	-$44.2	-$46.7	-$30.2
2012	-$49.9	-$57.4	-$35.0
2013	-$56.3	-$68.9	-$40.4
2014	-$63.4	-$80.7	-$46.0
2015	-$71.1	-$92.8	-$51.9
2016	-$79.5	-$105.5	-$58.6
2017	-$88.8	-$118.7	-$66.4
2008-2017	-$557.3	-$653.2	-$394.9

a/ Excludes wage effects.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

By 2017 provider payment rates in Health Care for America will be substantially below private insurance payment rates assuming that private insurance spending continues to increase as currently projected. These lower payment rates may have the potential to limit enrollee access to certain providers, impact the quality of care for enrollees, and restrict the growth in technological advancements.

E. Cost and Coverage Impacts at Various Payroll Tax Rates

Under the Health Care for America Proposal, employers who do not offer coverage would be required to pay a 6 percent payroll tax to have their workers enrolled in Health Care for America. We assume that the higher the tax rate, the more likely it is that employers would decide to offer private coverage and the lower the tax rate, the more likely they would enroll workers in Health Care for America. Below we present a sensitivity analysis of the impact of a 5 percent and a 7 percent payroll tax rate on coverage, on national health spending, and on government, employer and family health spending.

1. Transitions in Coverage

As shown in ***Figure 19***, a lower payroll tax rate results in more people enrolling in Health Care for America. The lower the tax rate, the more financially attractive it becomes for employers to enroll their workers through Health Care for America instead of maintaining private coverage. The number of people enrolled in Health Care for America increases to 145.3 million under a 5 percent tax rate, compared to 128.6 million under a 6 percent tax rate and 115.2 million under a 7 percent tax rate.

Figure 19
Enrollment in Health Care for America Plan under Various Employer Payroll Tax Rates in 2007 (millions)

	Health Care for America Enrollment		
Coverage Under Current Law	5% Payroll Tax Rate	6% Payroll Tax Rate	7% Payroll Tax Rate
Employer [a/]	66.6	51.8	41.3
Non-Group [b/]	6.9	6.6	6.3
CHAMPUS/Other	0.0	0.0	0.0
Medicare (incl. dual eligibles)	0.0	0.0	0.0
Medicaid/SCHIP [c/]	33.6	33.5	32.3
Employer-Retiree	0.7	0.6	0.5
Uninsured [d/]	37.5	36.1	34.7
Total	145.3	128.6	115.2

a/ Assumes employer switch to Health Care for America Plan based on the difference in total premium cost from their current plan and the composite price elasticity based on the age and health status of their workforce.
b/ Assumes people with non-group coverage take employer coverage if offered. For non-workers we assume they switch to Health Care for America plan based on difference in price and a price elasticity based on age and health status.
c/ Assumes Medicaid and SCHIP enrollees take employer coverage if offered.
d/ Assumes all uninsured people take employer coverage if offered. Assumes uninsured non-workers purchase individual coverage based on difference in price from an individual policy under current law. Under the individual mandate we assume all legal residents who are in a family that files taxes purchase coverage. However, if premium costs after subsidies exceed 9% of income then we assume it is unaffordable and they do not purchase coverage.
Source: The Lewin Group estimates using the Health Benefits Simulation Model.

2. Impact on National Health Spending

As shown in ***Figure 20***, a 5 percent tax rate results in significantly higher savings in national health spending in comparison to the 6 percent tax rate. The difference in the tax rate would have a greater impact on employer behavior than other areas. Applying a 5 percent tax rate would result in national health savings of about $13.3 billion compared to $100 million at a 6 percent tax rate. There is no change in spending for newly insured or for the currently insured when a 5 percent tax rate is applied compared to a 6 percent tax rate. This is primarily because more employers currently offering coverage would simply switch their workers to Health Care

for America at a lower tax rate. Under both of these tax rates, the U.S. would spend $53.2 billion in health services for increased utilization for the newly insured and under-insured.

Much of the increased savings is attributable to higher enrollment in Health Care for America. The Health Care for America plans have lower provider payment levels, negotiated drug discounting power and lower administrative costs than most private plans, which in turn reduces total system spending. Higher drug discounts would result in greater savings under the 5 percent payroll tax compared to a 6 percent payroll tax, as more people become covered under Health Care for America and therefore, more drug benefits become subject to formularies and discounts. Likewise, more people enrolled in the plan would result in greater savings from requiring enrollees to select a medical home. Under a 5 percent payroll tax rate, the U.S. would save about $22.7 billion from the medical home and drug discounts compared to $20.5 billion under the 6 percent payroll tax. Savings in insurer administrative costs would increase to $33.3 billion under a 5 percent tax rate compared to $29.9 billion under a 6 percent tax rate.

Figure 20
Changes in National Health Spending under Health Care for America Proposal at Various Payroll Tax Rates in 2007 (billions)

	5% Payroll Tax Rate	6% Payroll Tax Rate	7% Payroll Tax Rate
Change in Health Services Expenditures	$53.2	$53.2	$53.2
Change in utilization for newly insured	$49.8	$49.8	$49.8
Change in utilization for currently insured	$3.4	$3.4	$3.4
Reimbursement Effects	($15.0)	($7.4)	($1.6)
Payments for previously uncompensated care	$16.9	$16.7	$16.5
Change in Provider Payment Levels [a/]	($41.9)	($29.0)	($19.2)
Increased Cost Shifting [b/]	$10.0	$4.9	$1.1
Negotiated Drug Discounts and Medical Home Requirement	($22.7)	($20.5)	($18.9)
Reduced Spending on Drugs due to Negotiated Discounts [c/]	($9.7)	($8.8)	($8.2)
Medical Home Requirement [d/]	($13.0)	($11.7)	($10.7)
Change in Administrative Cost of Programs and Insurance	($28.8)	($25.4)	($20.0)
Change in Insurer Administration	($33.3)	($29.9)	($24.5)
Eligibility Determination for Subsidies [e/]	$4.5	$4.5	$4.5
Total Change in National Health Spending	($13.3)	($0.1)	$12.7

a/ Assumes provider payment levels in Health Care for America Plan are based on Medicare payment rates. Payments were increased for enrollees previously covered by Medicaid by 14% for hospital services and 45% for physician services. Payment rates were reduced for enrollees previously covered under private insurance by 26% for hospitals services and 17% for physician services.
b/ Assumes 40 percent of change in provider payment rates are passed on to private health plans in the form of lower negotiated rates.
c/ Assumes the Health Care for America Plan will reduce prices for prescription drugs through negotiated drug discounts and strict formularies to levels similar to current large HMOs. We estimate this will reduce Rx costs by 19% for enrollees from private insurers and 35% for previously uninsured enrollees.
d/ All public HCA plan enrollees are required to have a Medical Home. We estimate a net 4.1% reduction in utilization for these enrollees.
e/ Assumes subsidies administered through federal income tax system and IRS budget increased by 25%.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Conversely, national health spending would increase by $12.7 billion if the payroll tax rate is increased to 7 percent as compared to a $100 million savings at a 6 percent payroll tax. This is due to having lower enrollment in Health Care for America.

Net program costs under Health Care for America increase as the tax rate decreases. The lower tax rates make Health Care for America more attractive to employers to switch workers and enrollment in Health Care for America is higher. The result is that it increases program costs as more people are covered through Health Care for America. Under the 5 percent tax rate,

program costs would be $467.1 billion, compared to $417.7 billion at a 6 percent tax rate and $383.2 billion at a 7 percent tax rate ***(Figure 21)***. However, the lower payroll tax generates less per-enrollee revenue. Under a 5 percent tax rate, program revenues would be $202.4 billion, compared to $187.1 billion under the 6 percent tax and $175.4 billion percent under a 7 percent tax rate. Overall, net program costs under a 5 percent tax rate would be $261.7 billion, compared to $230.6 billion at a 6 percent tax rate, and $207.8 at a 7 percent tax rate.

Figure 21
Health Care for America Costs and Revenues at Various Payroll Tax Rates (assumes program fully implemented in 2007)

	5% Payroll Tax Rate	6% Payroll Tax Rate	7% Payroll Tax Rate
Health Care for America - Program Costs (billions)	$467.1	$417.7	$383.2
Benefit Costs			
Covered Through Employer	$261.2	$214.7	$182.5
Covered as Individual (Medicaid Disabled)	$67.3	$67.3	$67.3
Covered as Individual (Other)	$108.6	$108.6	$108.6
Administrative Costs a/	$30.0	$27.1	$24.8
Health Care for America - Program Revenues (billions)	$202.4	$187.1	$175.4
Employer Premiums (payroll tax)	$95.6	$91.9	$88.6
Employee Premiums	$61.3	$49.3	$40.9
Individual Premiums b/	$31.0	$31.0	$31.0
Employer Transfer Premiums c/	$14.5	$14.9	$14.9
Net Program Costs/(Savings) (billions)	$264.7	$230.6	$207.8

a/ Includes administration of program and eligibility determination ($2.2 billion).
b/ Based on community-rated premiums in the program net of subsidies. There are no premiums for people below poverty and premiums are phased in through 400% of FPL.
c/ Assumes employers of workers who are covered as a dependent on the spouses Health Care for America plan pay percent of worker's wages to Health Care for America Plan.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

3. Impact on Health Spending by Stakeholder Group

Figure 22 shows the impact on governments, private employers, and households at the various payroll tax levels. The federal government spends less as the tax rate increases. This is because the net cost of Health Care for America is less at higher payroll tax rates due to receiving more revenue from employers at the higher tax rates. At the higher tax rates the federal government sees less additional tax revenue from the elimination of Section 125 exclusions since more workers would still have access to these programs than at the lower tax rates. We estimate that before wage effects, the federal government would spend $84.3 billion more under a 5 percent payroll tax compared to $53.4 under a 6 percent tax and $32.7 billion under the 7 percent tax rate.

Similarly, states and local governments would see reduced savings as the tax rate increases. Much of this difference in savings is due to the governments' decisions to switch employee

benefit plans to Health Care for America, and the gains achieved from eliminating the Section 125 tax exclusion also reduced. We estimate that states and local governments would save $37.2 billion if a 5 percent tax rate is applied, compared to $26.9 billion at a 6 percent tax rate, and $22.8 billion at a 7 percent tax rate.

Private employers achieve greater savings at lower tax rates as their cost of providing coverage privately is less expensive in comparison to the required payroll taxes. They would save $54.8 billion at a 5 percent tax rate and $10 billion at a 6 percent tax rate. Increasing the payroll tax rate to 7 percent would result in private employers spending $23.8 billion more on health care. Households save more at higher tax rates mainly because their out-of-pocket costs would be lower under their current insurance plans as compared to Health Care for America.

We assume that changes in employer spending are passed on to workers in the form of higher wages. As a result, we estimate that private employers would save $4.9 billion in early retiree benefits and pass on the remaining change in spending to their workers. Households would end up saving only $300 million under a 7 percent payroll tax compared to $43 billion under a 5 percent payroll tax after the wage effect. States and local governments also save less under higher taxes ($23.7 billion under a 5 percent tax compared to a $19.3 billion under a 7 percent payroll tax). Federal government spending would increase by $61.3 billion under a 5 percent tax compared to a $39.4 billion under a 7 percent payroll tax, after wage effects.

Figure 22
Change in Health Spending by Stakeholder Group under the Health Care for America Proposal at Various Payroll Tax Rates in 2007 (in billions)

	5% Payroll Tax Rate	6% Payroll Tax Rate	7% Payroll Tax Rate
Without Wage Effects			
Federal Government	$84.3	$53.4	$32.7
State and Local Government	($37.2)	($26.9)	($22.8)
Private Employers	($54.8)	($10.0)	$23.8
Households	($5.6)	($16.6)	($21.0)
With Wage Effects			
Federal Government	$61.3	$49.3	$39.4
State and Local Government	($23.7)	($21.2)	($19.3)
Private Employers	($4.9)	($4.9)	($4.9)
Households	($46.0)	($23.3)	($2.5)
Total Health Spending	($13.3)	($0.1)	$12.7

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

In ***Figure 23*** we present our estimates of the change in spending for the federal government under the Proposal at the various tax rates. The most significant impact on federal government spending results from the combined effect of the Section 125 tax exclusion and the wage effect at the various tax levels. Under the 6 percent tax rate, the savings from elimination of the tax exclusion would be $13.4 billion compared to $35.6 billion under a 5 percent payroll tax and only $500 million under a 7 percent tax rate. As more employers switch from private coverage to Health Care for America under a lower tax rate, more people lose the tax exclusion resulting in higher tax revenues. We treat this higher tax revenue as a savings in federal government health spending. However, because net Health Care for America costs are higher at the lower tax rate, these savings are not sufficient to offset the overall federal cost of Health Care for America. So, the federal government would spend $61.3 billion more under the 5 percent tax compared to $49.3 billion under the 6 percent tax rate and $39.4 billion under the 7 percent tax rate.

Figure 23
Change in Federal Government Spending Under Health Care for America Proposal at Various Payroll Tax Rates in 2007 (billions)

	5% Payroll Tax Rate	6% Payroll Tax Rate	7% Payroll Tax Rate
Federal Program Costs of Health Care for America			
Net Federal Costs	$264.7	$230.6	$207.8
Federal Program Revenues and Offsets			
Federal Employee Health Benefits	($0.8)	($0.8)	($0.8)
Workers and Dependents	$3.2	$3.0	$2.6
Early Retirees	($0.8)	($0.8)	($0.8)
Wage Effects [a/]	($3.2)	($3.0)	($2.6)
Medicaid and SCHIP Programs	($160.1)	($160.1)	($160.1)
Federal Share of Reduced Medicaid and SCHIP Spending	($91.3)	($91.3)	($91.3)
State Maintenance of Effort	($68.8)	($68.8)	($68.8)
Employer Transfers for Working Medicare and CHAMPUS [b/]	($6.9)	($7.0)	($7.0)
Tax Revenue Gain Due to Tax Effects [c/]	($35.6)	($13.4)	($0.5)
Elimination of Section 125 Plan Tax Exclusion for Workers who enroll in Health Care for America	($15.8)	($12.3)	($10.0)
Wage Effects	($19.8)	($1.1)	$9.5
Total Program Revenues and Offsets	($203.4)	($181.3)	($168.4)
Net Cost/(Savings) to Federal Government	$61.3	$49.3	$39.4

a/ Assumes reduced employer costs are passed on to workers in the form of higher wage increases.
b/ Employers pay payroll tax for working Medicare and CHAMPUS beneficiaries that opt-out of Health Care for America Plan.
c/ Increase in tax revenue is counted as a reduction in federal government health spending.
Source: The Lewin Group estimates using the Health Benefits Simulation Model.

States and local governments would see reduced savings as the tax rate increases ***(Figure 24)***. Much of this loss in savings is because fewer workers would be switched to Health Care for America at the higher tax rates, and the gains achieved from eliminating the Section 125 tax exclusion would also be reduced. We estimate that states and local governments would save $23.7 billion, after the wage effect, if a 5 percent tax rate is applied, compared to $21.2 billion at a 6 percent tax rate, and $19.3 billion at a 7 percent tax rate.

Figure 24
Change in State and Local Government Spending Under Health Care for America Proposal at Various Payroll Tax Rates in 2007 (billions)

	5% Payroll Tax Rate	6% Payroll Tax Rate	7% Payroll Tax Rate
State and Local Government Employee Health Benefits	($2.2)	($2.2)	($2.2)
Workers and Dependents	($15.5)	($5.8)	($2.1)
Early Retirees	($2.2)	($2.2)	($2.2)
Wage Effects [a/]	$15.5	$5.8	$2.1
Medicaid and SCHIP Programs	$0.0	$0.0	$0.0
State Share of Reduced Medicaid and SCHIP Spending	($68.8)	($68.8)	($68.8)
Maintenance of Effort Payment to Federal Government	($68.8)	($68.8)	($68.8)
Savings to Other Health Safety Net Programs	($17.9)	($17.7)	($17.5)
Tax Revenue Loss Due to Wage Effects [b/]	($3.6)	($1.3)	$0.4
Elimination of Section 125 Plan Tax Exclusion for Workers who enroll in Health Care for America	($1.6)	($1.2)	($1.0)
Wage Effects	($2.0)	($0.1)	$1.4
Net Cost/(Savings) to State and Local Governments	($23.7)	($21.2)	($19.3)

a/ Assumes reduced employer costs are passed on to workers in the form of higher wage increases.
b/ Reduction in tax revenue is counted as an increase in state and local government health spending.
Source: The Lewin Group estimates using the Health Benefits Simulation Model.

Private employers who currently offer coverage would achieve greater savings at lower tax rates ***(Figure 25)***. They would save $102.4 billion at a 5 percent tax rate, $65.6 billion at a 6 percent tax rate, and $39.6 billion at a 7 percent tax rate, before taking into account the wage effect. This is because at lower tax rates, more employers find Health Care for America financially attractive compared to offering private coverage. We assume that these savings would be passed on to workers in the form of higher wages.

Figure 25
Changes in Private Employer Health Spending Under Health Care for America at Various Payroll Tax Rates in 2007 (Currently Insuring Employers)

	5% Payroll Tax Rate	6% Payroll Tax Rate	7% Payroll Tax Rate
Private Employer Spending Under Current Law = $442.7 billion			
Private Employer Spending Under the Health Care for America Proposal (billions)			
Workers and Dependents in firms that continue to offer coverage	$241.4	$289.4	$326.0
Continued Retiree Coverage	$30.3	$30.3	$30.3
Health Care for America Premiums (payroll tax)	$59.3	$54.6	$50.1
Increased Cost Shifting	$5.5	$2.7	$0.6
Transfer Payments Made [a/]	$18.8	$22.6	$26.5
Transfer Payments Received [b/]	($18.6)	($25.3)	($32.7)
Increased Payroll Taxes [c/]	$3.6	$2.8	$2.3
Total	$340.3	$377.1	$403.1
Net Change (before wage effects)	($102.4)	($65.6)	($39.6)

a/ Transfer payments are made by employers for workers who opt out of employer coverage due to coverage from another source.
b/ Employers that offer private coverage may receive transfer payments from another employer for their workers taking coverage as dependents on the spouse's plan.
c/ Employers will be responsible for their share of increased payroll taxes due to elimination of Section 125 plan tax exclusion for workers enrolled in Health Care for America.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Employers who do not currently offer coverage would experience an increase in health spending under all three tax rate scenarios ***(Figure 26)***. However, the higher the tax rate, the more these employers will have to spend. Overall, private employers who do not offer coverage would spend $63.4 billion more under a 7 percent tax, compared to $55.6 billion more under a 6 percent tax and $47.6 billion more under a 5 percent payroll tax.

Figure 26
Changes in Private Employer Health Spending Under Health Care for America at Various Payroll Tax Rates in 2007 (Currently Non-Insuring Employers)

	5% Payroll Tax Rate	6% Payroll Tax Rate	7% Payroll Tax Rate
Private Employer Spending Under the Health Care for America Proposal (billions)			
Workers and Dependents in firms that continue to offer coverage	$7.5	$8.4	$9.3
Continued Retiree Coverage	--	--	--
Health Care for America Premiums (6% payroll)	$20.2	$23.2	$25.9
Increased Cost Shifting	--	--	--
Transfer Payments Made a/	$20.9	$25.2	$29.6
Transfer Payments Received b/	($1.0)	($1.2)	($1.4)
Increased Payroll Taxes c/	--	--	--
Net Change (before wage effects)	$47.6	$55.6	$63.4

a/ Transfer payments are made by employers for workers who opt out of employer coverage due to coverage from another source.
b/ Employers that offer private coverage may receive transfer payments from another employer for their workers taking coverage as dependents on the spouse's plan.
c/ Employers will be responsible for their share of increased payroll taxes due to elimination of Section 125 plan tax exclusion for workers enrolled in Health Care for America.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Households would achieve lower savings under the higher tax rate ***(Figure 27)***. The increase in premium spending net of subsidies would be higher at the 7 percent tax rate ($3.8 billion) than the lower tax rates. The increase in household premiums is about the same at the 5 percent tax rate or a 6 percent tax rate. Savings in out-of-pocket spending would be greater under the 7 percent payroll tax rate ($33.5 billion in savings), compared to $20.6 billion savings under a 5 percent tax rate and $28.8 billion saved under the 6 percent tax rate. Spending also is decreased as more workers stay in their employer's private plan and take advantage of the Section 125 tax exclusion. As employers spend less on health care, the savings are passed on to workers in the form of higher wages. The net savings for families would be $46 billion under a 5 percent tax, $23.3 billion under a 6 percent tax and $2.5 billion under a 7 percent tax.

Figure 27
Impact of Health Care for America Proposal at Various Payroll Tax Rates on Family Health Spending in 2007 (billions)

	5% Payroll Tax Rate	6% Payroll Tax Rate	7% Payroll Tax Rate
Change in Premiums	$1.2	$1.5	$3.8
Change in Out-of-pocket Payments	($20.6)	($28.8)	($33.5)
Elimination of Section 125 Plan Tax Exclusion for Workers who enroll in Health Care for America	$13.8	$10.7	$8.7
Net Change in Spending Before Wage Effects	($5.6)	($16.6)	($21.0)
After Tax Wage Effects a/	($40.4)	($6.7)	$18.5
Net Change in Spending After Wage Effects	($46.0)	($23.3)	($2.5)

a/ The increase in after-tax wage income resulting from reduced costs to employers is counted here as a reduction in family health spending.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

F. Analysis of Potential Adverse Selection in Health Care for America

We evaluated the potential adverse selection effects in Health Care for America at different tax rate scenarios. As shown in ***Figure 28*** and ***Figure 29***, the following impacts occur as the payroll tax decreases:

- More employers decide to enroll in Health Care for America and less offer coverage;
- The distribution of enrollees in Health Care for America shifts to older workers as compared to enrollees in private insurance;
- Average per member per month spending in Health Care for America increases (assuming private insurance payment levels and excluding administrative costs, to allow for an "apples-to-apples" comparison); and
- Average per member per month spending in private insurance outside Health Care for America pool decreases (again, assuming private insurance payment levels and excluding administrative costs, to allow for an "apples-to-apples" comparison).

We estimate that under a 5 percent payroll tax rate, 145.3 million people would enroll in Health Care for America compared to 103.5 million in private plans. However, the monthly cost per member is only two dollars higher in Health Care for America than in private plans. Under a 6 percent payroll tax rate, 120.3 million people would enroll in private plans compared to 128.6 million in Health Care for America plan. We estimate that the monthly cost per member would be $10 less in Health Care for America pool than outside the pool. Under a 7 percent tax rate, enrollment is higher in private plans (133.6 people would enroll in private plans). Enrollment in Health Care for America would drop to 115.2 million and the monthly cost per member would be $19 less in the Health Care for America pool as compared to private insurance outside the pool ***(Figure 28)***.

Figure 28
Analyses of Potential Adverse Selection into Health Care for America:
Per Member Per Month (PMPM) Costs and Enrollment

Payroll Tax Rate	Private Insurance Enrollment (millions)	Health Care for America Enrollment (millions) a/	PMPM Spending – Enrollees in Private Insurance	PMPM Spending – Health Care for America Enrollees a/	PMPM Spending Difference
5% Tax Rate	103.5	145.3	$356	$358	$2
6% Tax Rate	120.3	128.6	$362	$352	($10)
7% Tax Rate	133.6	115.2	$365	$346	($19)

a/ Excludes Medicaid beneficiaries who are moved to the Health Care for America Plan, because they did not select into the plan but were mandated to enroll. Average spending for enrollees in private insurance and Health Care for America is estimated at private insurance payment levels for both groups and administrative costs have been excluded. Thus, differences in the two spending figures are based on utilization of health services only.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The monthly costs per member are compared in order to assess whether significant adverse selection against Health Care for America would occur. For such purposes, what is needed is an "apples-to-apples" comparison of the health care costs of enrollees. To obtain such a comparison, we have assumed that both Health Care for America and private plans outside the HCA pool use the same payment rates (for this illustration, private insurance rates) and we have excluded administrative costs from consideration. Thus, differences in the two spending figures are based on utilization of health services only. In practice, as reported earlier, we estimate average enrollee costs in Health Care for America would be about $3,250 compared to $4,230 under a private insurance product in 2007.

As the payroll tax rates decrease, the distribution of workers in the Health Care for America pool shifts to slightly to older workers ***(Figure 29)***. Conversely, the distribution of people with private coverage outside the HCA pool shifts to younger workers as the tax rate decreases. Under the pay-or-play model, employers would offer coverage if private market premiums are less than the Health Care for America payroll tax. As the payroll tax rate decreases, the employers that would continue to offer coverage would have younger and lower-cost workers. Thus with a low payroll tax, employers would only offer coverage if their private market premium costs were low, and this would require predominantly young, healthy workers.

Figure 29
Analyses of Potential Adverse Selection into HCA Pool:
Average and Median Age of Enrollees in Private Health Insurance versus Health Care for America at Various Employer Payroll Tax Rates

	Average Age of Enrollee			Median Age of Enrollee		
Payroll Tax Rate	Private Insurance	Health Care for America [a/]	Difference	Private Insurance	Health Care for America [a/]	Difference
5% Tax Rate	31.3	33.2	1.9	32.0	34.0	2.0
6% Tax Rate	31.4	32.9	1.5	32.0	33.0	1.0
7% Tax Rate	31.5	32.6	1.1	33.0	33.0	0.0

a/ Excludes Medicaid beneficiaries that are moved to the Health Care for America Plan, because they did not select into the Plan but were mandated to enroll.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

We also analyzed enrollment in and out of the Health Care for America Plan based on health status. Overall, we only found slight differences in the health status of enrollees between the two types of plans under all three tax rates ***(Figure 30)***. For example, under the 5 percent payroll tax rate scenario, the proportion of enrollees with a health status of "Excellent/Very Good" was 5 percent lower in Health Care for America than in private plans. This proportion changes to 5.7 percent lower under the 6 percent payroll tax, and 5.6 percent under a 7 percent payroll tax scenario. So there is no significant change in the distribution of enrollees based on health status in Health Care for America versus the private plans across the various tax rates. This is also true for enrollees with health status of "Good", "Fair" or "Poor." There was also no significant difference in enrollment distribution in and out of the pool across the various tax rates. Therefore, applying a 5 percent, 6 percent or a 7 percent payroll tax did not appear to result in any significant adverse selection.

Figure 30
Distribution of Private Insurance Enrollees Compared to Public Plan Enrollees at Various Payroll Tax Rates

	5% Payroll Tax Rate			6% Payroll Tax Rate			7% Payroll Tax Rate		
	Private Coverage	HCA	Difference	Private Coverage	HCA	Difference	Private Coverage	HCA	Difference
				Age of Enrollee					
Under 6	9.0%	9.0%	0.1%	8.9%	9.1%	0.2%	8.9%	9.1%	0.2%
6-18	21.2%	19.7%	-1.5%	21.3%	19.4%	-1.9%	21.2%	19.2%	-1.9%
19-24	8.5%	10.8%	2.3%	8.5%	11.3%	2.8%	8.3%	11.9%	3.6%
25-34	14.7%	14.7%	0.0%	14.7%	14.7%	0.1%	14.6%	14.8%	0.2%
35-44	18.1%	16.8%	-1.3%	17.9%	16.8%	-1.1%	18.0%	16.6%	-1.4%
45-54	18.0%	15.8%	-2.2%	18.1%	15.3%	-2.7%	18.0%	15.1%	-2.9%
55-64	9.4%	11.7%	2.3%	9.6%	11.8%	2.2%	9.9%	11.8%	2.0%
65 & Over	1.1%	1.5%	0.4%	1.1%	1.5%	0.4%	1.1%	1.5%	0.4%
Total	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%
				Health Status of Enrollee					
Excellent /Very Good	83.8%	78.8%	-5.0%	83.7%	78.0%	-5.7%	83.3%	77.8%	-5.6%
Good	13.2%	17.2%	4.0%	13.3%	17.8%	4.5%	13.7%	17.9%	4.2%
Fair	2.5%	3.2%	0.7%	2.5%	3.3%	0.9%	2.4%	3.5%	1.0%
Poor	0.5%	0.8%	0.3%	0.5%	0.8%	0.3%	0.5%	0.8%	0.3%
TOTAL	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%

a/ Excludes Medicaid beneficiaries who are moved to the Health Care for America Plan, because they did not select into the Plan but were mandated to enroll.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).