



# McCain and Obama Health Care Policies: Cost and Coverage Compared

October 15, 2008



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October 8, 2008  
(Revised October 15, 2008)







## PREFACE

Our objective in performing this study was to provide a nonpartisan objective analysis of the health reform proposals developed by the Presidential candidates. They both have very different visions for the future of health care in this country. Both candidates build upon the existing systems while incorporating bold new policies that in some cases are untested.

The McCain plan would stress increased coverage under private insurance without a requirement for employers to pay towards worker coverage. By contrast, the Obama plan requires many employers to contribute to the cost of covering their workers and greatly expands coverage under public programs. The Obama plan stresses increased regulation of insurance while the McCain plan emphasizes the effective deregulation of insurance. The McCain plan also emphasizes tax reform and deregulation of benefits to reduce costs while the Obama plan establishes a national minimum standard of coverage and seeks to control costs through specific government interventions.

Our approach was to give full consideration to these dichotomous views of the role of government in assuring coverage and controlling costs. We did this by explaining the theory and rationale behind each major element of these proposals. We reviewed the research and evidence available on the impact of each major feature of each candidate's plan to develop a model of their likely effects. This allowed us to make our estimates as "evidence-based" as possible. This work is explained in detail in the three technical appendices to this report to assure the transparency of our work.

We used consistent methods and assumptions throughout so that differences in estimated impacts are attributed to differences in policy rather than mere discrepancies in data and assumptions. For example, we used identical price response assumptions from employers and individuals, and changes in health services utilization for newly insured people, given their benefits package. We used The Lewin Group Health Benefits Simulation Model (HBSM) to simulate both proposals using the same data and consistent methodologies.

Because many of the details of both proposals are not available, we needed to develop a series of uniform rules for interpreting their proposals. For example, we assumed that neither of these proposals creates "unfunded mandates" for spending by state governments unless stated otherwise by the campaigns. Thus, we assumed that all new public expenditures under the proposal are funded by the federal government through either the funding mechanisms specified by the campaign for the through increases in federal deficit spending.

For example, this means that we assumed that states are not required to share the cost of Medicaid expansions under Obama's plan, and that the federal government would pay the full cost of these expansions. Also, we assumed that states are not required to assist in funding the high-risk pools under the McCain plan. Thus, the federal government is assumed to cover the cost of whatever is not collected through the insurer assessment as specified by the McCain campaign.

We assumed that individual elements of the candidates' proposals have no effect unless the candidate specifies how these programs would be implemented. Stating that the candidate would "promote" a particular cost containment method was assumed to have no effect unless it

was associated with: funding for its use and promulgation; requirements for providers or insurers to adopt the approach; or changes in provider payment systems that alter financial incentives for providers or patients.

We credited the candidates with only those effects that would be attributable to the policies proposed by the campaigns. For example, both candidates speak of expanded use of health information technology. However, the use of HIT in health care is rapidly expanding and is expected to increase throughout the next decade without government intervention. Thus, most of the savings expected from the adoption of HIT is already in our “baseline” projections of spending under current law. Thus, the most savings we can attribute to the candidates’ proposals would be those resulting from accelerated adoption, and even then, only in cases where the candidate does more than simply state that he would “promote” its use.

## ABOUT THE LEWIN GROUP

The Lewin Group has a 38-year history of providing objective, independent health and human services policy analysis and consulting. As we did in 2004, we decided to conduct an independent analysis of the two major 2008 Presidential candidates' health care proposals. We notified each campaign that we were producing nonpartisan comparative analyses of the cost and coverage impacts of the proposal health care policies of Senators John McCain and Barack Obama. In developing our estimates, we used publicly available information on plan specifications and information received directly from the campaigns.

The Lewin Group has over 22 years experience in analyzing the impact of health reform initiatives on major stakeholder groups including employers, providers, governments and consumers. We are committed to providing unbiased and nonpartisan analyses of the likely impacts of proposals to change health care coverage and financing. Our financial analyses of health reform impacts first came to prominence in 1989 when we provided estimates of the cost and coverage impacts of alternative universal coverage proposals for the Bipartisan Congressional Commission on Health Care. Lewin analyses are primarily based upon a microsimulation model of the US health care system called the Health Benefits Simulation Model (HBSM) which has been continuously refined since its development in 1989.

The Lewin Group recently completed analyses of 10 health reform proposals introduced as legislation in the US Congress for the Commonwealth Fund. We also assisted in designing the "Healthy Americans Act" for Senator Wyden of Oregon and provided analyses of the "Health Care for America" proposal for the Economic Policy Institute (EPI). We are proud that over the years, we have been asked to provide technical support in designing and evaluating health proposals for lawmakers, foundations and stakeholder groups.

This analysis was directed by Mr. John Sheils, a Senior Vice President with The Lewin Group, who is a nationally known expert on designing and evaluating health coverage expansion proposals. He joined Lewin in 1980 and has worked to establish the firm as one of the few independent sources of information on the financial impacts of major health reform initiatives. He has testified before various congressional committees and often works directly with members of Congress in evaluating and developing health reform initiatives.

Mr. Sheils was assisted by Mr. Randall Haught, a Senior Scientist at The Lewin Group. Mr. Haught has worked for more than 15 years with Mr. Sheils in the development and refinement of HBSM. He has extensive experience in estimating the impacts of health reform initiatives on health spending.

This study and technical appendices also are available on The Lewin Group's Website at [www.lewin.com](http://www.lewin.com).



## ACKNOWLEDGEMENTS

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### Appendices in Separate Volume

Appendix A: Analysis of Senator McCain's Health Proposals by Major Provision

Appendix B: Analysis of Senator Obama's Health Proposals by Major Provision

Appendix C: Uniform Methodology and Data





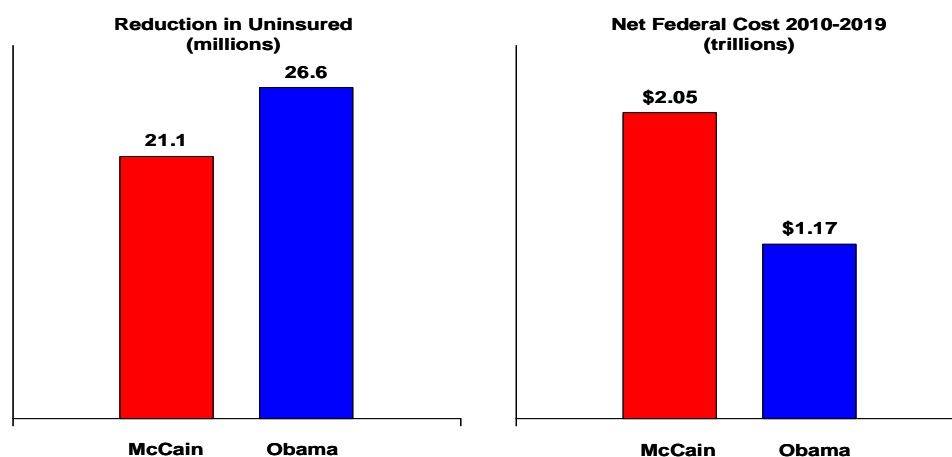




## EXECUTIVE SUMMARY

In this study, The Lewin Group estimated the cost and coverage impacts of the health reform proposals introduced by Senators McCain and Obama. Our key findings are that the McCain proposal would reduce the number of uninsured from a projected number of 48.9 million people in 2010 by 21.1 million people if fully implemented in that year (*Figure ES-1*). The Obama plan would reduce the number of uninsured by 26.6 million people. The McCain proposal would result in a net increase in federal spending (i.e., net of offsets) of \$2.05 trillion over the 2010 through 2019 period compared with a net federal cost of \$1.17 trillion under the Obama plan over this same ten-year period.

**Figure ES-1**  
Changes in Uninsured and Net Federal Cost of Candidates' Health Proposals



a/ Uninsured estimates assume full implementation of these plans in 2010.  
Source: The Lewin Group estimates.

## The Candidates' Proposals

The McCain proposal would expand coverage through private insurance and decrease regulation of health insurance markets. His plan would provide a refundable tax credit of \$2,500 for single filers and \$5,000 for families that have private health insurance from an employer or as an individual in the non-group market. Insurers would be permitted to sell insurance across state lines, thus sidestepping state minimum benefit and insurance rating regulations.

The McCain proposal would establish federally subsidized high-risk pools called the Guaranteed Access Program (GAP) to cover those denied coverage due to health status. The Campaign indicates that half of the losses under the GAP would be paid with an assessment on private insurance with the federal government providing the remaining half.

The Obama proposal would expand coverage through public and private insurance and increase federal regulation of insurance markets. His proposal would expand Medicaid eligibility to include all very low-income adults and would provide premium subsidies for people with low to moderate incomes. Insurers would be prohibited from denying coverage or

setting insurance premiums on the basis of health status. Also, the Obama plan would provide small employers with a tax credit for the purchase of insurance and would create a federally subsidized reinsurance program to cover “catastrophic health” expenses in employer plans.

Senator Obama’s plan would also create a “National Exchange” offering a selection of private health insurance options comparable to those now offered to members of Congress and federal workers. The exchange would be open to individuals, the self-employed and small employers. In addition, the Obama proposal would create a new publicly-operated insurance program called the “National Plan” that would be available as an alternative to private coverage in the National Exchange.

Both plans have features designed to reduce health care costs. Senator McCain would reduce premiums by sidestepping state mandated benefit laws and would increase incentives to purchase lower cost health insurance by eliminating the income tax exclusion for employer-sponsored insurance (ESI).<sup>1</sup> Unlike the McCain plan, the Obama proposal would establish a minimum standard of covered benefits. Obama would also require the use of care coordination services for the chronically ill in Medicare and other federal programs.

## Employer Coverage

We estimate that in 2010 there will be about 157.4 million people with ESI including workers, dependents and retirees. Under the McCain plan, there would be a net decline in the number of people with ESI of 9.4 million people (*Figure ES-2*). The number of people with ESI would increase by 4.7 million people under the Obama plan primarily due to the requirement for medium and large employers to contribute to the cost of worker coverage. However, these figures mask large shifts in coverage for employers.

Under the McCain plan, 16.1 million workers and dependents would be in a firm that discontinues their plan. This happens because the McCain plan reduces or eliminates the relative cost advantages of ESI by: allowing the tax credit to be used for non-group coverage; eliminating the income tax exclusion for employer-based insurance; and by creating a federally subsidized high risk pool for the chronically ill in the individual market.

This loss of ESI under McCain plan is partly offset by an increase in employer coverage of 6.4 million people in firms that start to offer coverage. These include people in firms with younger and healthier workers who would see a reduction in premiums due to cross-state sale of insurance under the McCain plan.

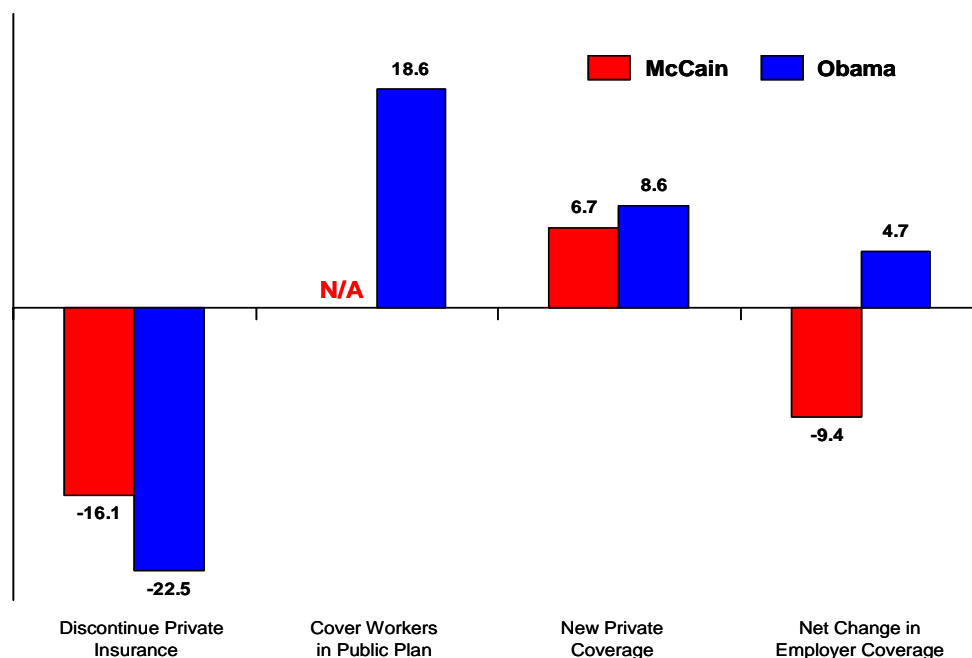
We estimate that about 22.1 million workers and dependents are in firms that would discontinue their private health insurance under the Obama plan. However, much of this includes employers who discontinue their private coverage to enroll in the National Plan. We would see this shift to the National Plan because it is likely to have lower premiums due to the use of lower health care provider payment levels, as is in Medicare and other government

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<sup>1</sup> The exclusion of employer health benefits for Social Security and Medicare payroll taxes would be continued. Communication with Douglas Holtz-Eakin, Senior Policy Advisor, McCain Campaign

programs. In all, 18.6 million people would be in a firm that decides to purchase public coverage for their workers under the National Plan.

Figure ES-2  
Changes in Employer Coverage under the Candidates' Proposals  
(millions)



Source: The Lewin Group estimates.

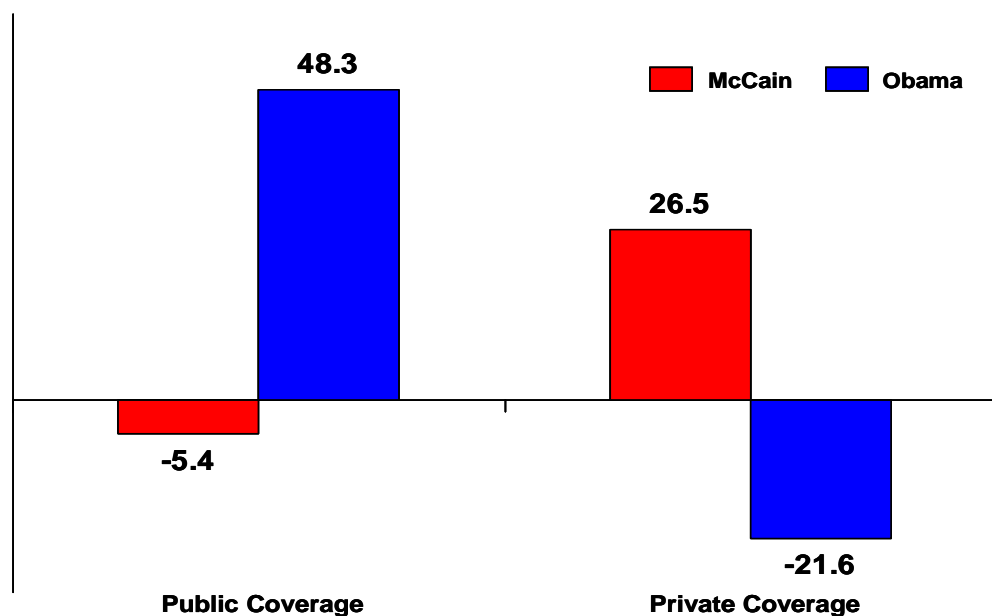
This loss of private employer coverage under the Obama plan would be further offset by an increase in private ESI of 8.6 million people in firms that decide to purchase private coverage for their workers. This will occur among medium and large firms that find it less costly to cover their workers than pay the tax, in part due to the Obama's proposed employer reinsurance program. Those who obtain private ESI in this way would tend to be in currently non-insuring medium and large firms that would not be eligible to participate in the National Plan under the Obama proposal.

### Changes in Public and Private Coverage

The number of people with public coverage would decline by 5.4 million people under the McCain plan, primarily due to a new option for states to use Medicaid funding to enroll Medicaid beneficiaries in private insurance with the aid of the tax credit (*Figure ES-3*). The number of people with public coverage would increase by about 48.3 million people under the Obama plan. These include 16.6 million new Medicaid enrollees, and about 31.7 million people who would enroll in the new government operated National Plan, including the 18.6 million workers and dependents in firms purchasing coverage through the National Plan.

Coverage under private insurance, including ESI and non-group insurance, would increase by 26.5 million people under the McCain plan. This reflects the availability of the tax credit for private non-group insurance and the option for states to use Medicaid funds to cover participants under private insurance. In contrast, private coverage would fall under the Obama plan by 21.6 million people as employers and individuals drop their private insurance to enroll in the National Plan and the expanded Medicaid program.

**Figure ES-3**  
Change in Public and Private Coverage under Candidates' Proposals <sup>a/</sup>  
(millions)



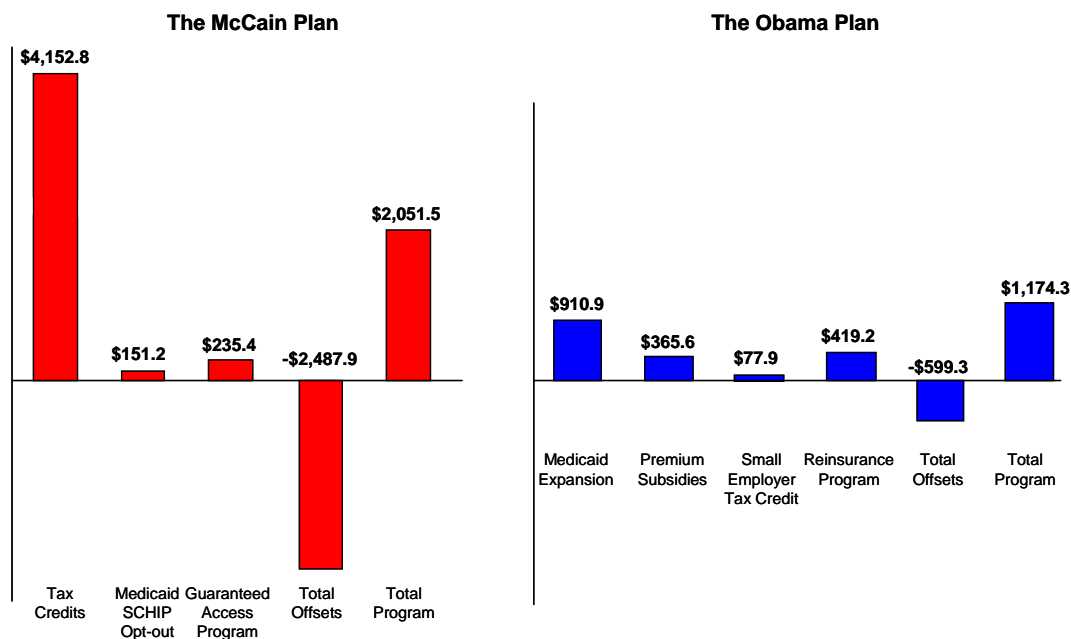
a/ Under the Obama plan, public coverage includes Medicaid and the National Plan, including those whose employer is covering them under the National Plan. Under the McCain plan, public coverage includes Medicaid and people enrolled in the newly created high-risk pools under GAP.

Source: The Lewin Group estimates.

## Federal Costs

The McCain plan would increase net federal spending by \$2.05 trillion over the 2010 through 2019 period. This includes new federal spending under the proposal net of various offsets. The tax credits would cost \$4.15 trillion over these ten years (*Figure ES-3*). The federally subsidized GAP high risk pools would cost the federal government \$235.4 billion, which is net of insurer assessments that cover half of the cost of the program. Also, the McCain plan would permit states to use Medicaid funds together with the tax credit to cover Medicaid recipients under private insurance, thus adding another \$151.2 billion to federal costs.

Figure ES-4  
Total Federal Health Spending for Candidate's Plans Compared: 2010-2019  
(billions)



Source: The Lewin Group estimates.

The McCain plan would have \$2.49 trillion in offsets to this new federal spending, of which about \$1.89 trillion would be increased tax revenues from eliminating the income tax exclusion for ESI benefits. For most people, the amount of the tax credit would exceed the increased taxes they would pay by eliminating the exclusion for ESI. There would be additional savings to Medicare (\$144.4 billion) from revising the payment system to emphasize coordinated care for people with chronic conditions.

The Obama proposal would result in a net increase in federal spending of \$1.17 trillion over the 2010 through 2019 period. The Medicaid expansion would cost \$910.9 billion, the full cost of which we assume would be paid by the federal government.<sup>2</sup> The insurance premium subsidies would cost \$365.6 billion. Senator Obama's proposed small employer tax credit and the employer reinsurance plan would cost \$77.9 billion and \$419.2 billion respectively over ten years.

There would be \$599.3 billion in offsets to federal costs under the Obama plan, including \$226.0 billion in payroll tax payments for employers who pay the payroll tax rather than provide insurance. Offsets also include \$135.3 billion from eliminating Medicare Advantage plan over-payments, and \$270.0 billion in savings to public programs due to various system savings initiatives under the proposal.

<sup>2</sup> We assume these proposals do not result in unfunded mandates for state governments unless otherwise specified.

## Financing

Neither candidate explains how he would pay for his program. Consequently, it is impossible to completely assess the net impact of these proposals on consumers until the financing methods are known. However, we provide a partial analysis of changes in family spending under the various provisions of these proposals below.









## INTRODUCTION

This study provides estimates of the cost and coverage impacts of the health care plans introduced by Senators John McCain and Barack Obama in the 2008 presidential campaign. Both candidates propose policies to expand health insurance coverage to many of the 45 million Americans who lack such coverage today. Neither plan includes a mandate for all Americans to have insurance, although the Obama plan does require parents to cover their children. The plans also include provisions that are designed to help reduce health care costs in the private and public sectors.

Wherever possible, we based our specifications of the candidates' plans on written materials provided by the campaigns. Where details are lacking, we specified assumptions on how these programs would operate, in order to estimate their potential impacts. We used consistent criteria to determine these details. We provide a detailed description of these specifications and the methods used to determine their impacts in *Appendices A* and *B* of this report.

We estimated the impact of the McCain and Obama plans using the Health Benefits Simulation Model (HBSM) developed by The Lewin Group, as described in *Appendix C*. We used uniform data and assumptions for both plans, to assure that differences in estimated impacts are attributed to differences in program design rather than mere inconsistencies in assumptions.

In the following sections, we summarize the details of these plans and present our estimates of the number of people likely to take insurance coverage under each plan. We also estimated the cost impacts for the federal government, state and local governments, employers and consumers. Our results are presented in the following sections:

- The Candidates' Health Reform Proposals
- Changes in Sources of Insurance Coverage;
- Coverage for the Uninsured;
- Impact on National Health Spending;
- Federal Spending and Revenues;
- State Government Spending and Revenues;
- Employer Impacts;
- Impacts on Consumers; and
- Caveats.

## A. The Candidates' Health Reform Proposals

The candidates take decidedly different approaches to expanding health insurance coverage. The McCain plan relies on broadening the private insurance market with the addition of a tax credit applicable to the purchase of all private insurance, including Employer Sponsored Insurance (ESI) and individually purchased non-group coverage. State Medicaid programs would also be permitted to cover beneficiaries under private insurance with the help of the credit. The Obama plan expands eligibility for low-income adults under Medicaid, creates a premium subsidy for people with low-to-moderate incomes and creates a National Exchange offering a choice of health insurance options, including a newly created government operated health plan that would be available nationally (*Figure 1*).

The centerpiece of the McCain plan is a new refundable tax credit of \$2,500 for single coverage and \$5,000 for family coverage that would be available to both those who have employer-sponsored insurance (ESI) and those who purchase non-group insurance as individuals. The credit replaces the current income tax exclusion for ESI, which means that people would be required to pay income tax on the value of their health benefits.<sup>3</sup> Where people obtain coverage for less than the amount of the tax credit, they may deposit the remainder of the credit in a Health Savings Account (HSA).

The Obama plan would expand health insurance coverage through public programs and private health insurance. The plan requires that medium and large employers (we assume this means firms with 25 or more workers) either offer insurance or pay a tax equal to a percentage of employee wages and salaries. It also encourages small employers to offer coverage by providing a new tax credit for small firms offering coverage. The proposal also creates a reinsurance program for all employers that would cover a portion of costs for individual group members with "catastrophic" health care costs.<sup>4</sup>

Senator Obama's plan also expands Medicaid to cover very low-income adults and provides subsidies for the purchase of insurance to people with low-to-moderate incomes who do not have access to ESI. Because the plan does not specify income eligibility levels for these programs, we assumed that Medicaid is expanded for all adults to 150 percent of the federal poverty level (FPL). We assumed that premium subsidies would be available on a sliding-scale for incomes between 150 percent and 400 percent of the FPL (i.e., between about \$30,000 and \$80,000 for a family of four).

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<sup>3</sup> The tax exclusion for Social Security and Medicare payroll taxes would be retained. The exclusion for worker contributions under Section 125 plans is also eliminated. Employers would continue to be able to deduct health benefits as a cost of doing business. Source: Communication with Douglas Holtz-Eakin of the McCain campaign

<sup>4</sup> The plan does not specify the spending that would meet the definition of "catastrophic." Our assumptions on how this would be defined and the amounts that would be covered are discussed below.

**Figure 1**  
**Summary Specifications of Candidates' Proposals**

	The McCain Proposal	The Obama Proposal
Mandate to Have Insurance	None	Children only
Role of Employer-Sponsored Insurance (ESI)	None required	Must provide coverage or pay a tax. Also provides up to 50% premium subsidies for small firms
Premium Subsidies	Refundable flat tax credit of \$2,500 single and \$5,000 family	Premium subsidies provided; amounts not specified
Medicaid Expansion	None; Permits states to use Medicaid funds to purchase private insurance for enrollees with the aid of the credit	Expanded for very low-income people
New Public Insurance Plan	None	"National Plan" option for small firms and all without ESI
Creates Regional "Exchange" With Coverage Options	None	Creates exchange modeled on FEHBP as an alternative to non-group market
Options for Workers with Access to Employer Coverage	No provisions	Public plan available only to small firms and individuals without employer coverage
Employer Health Benefits Tax Exclusion	Replaced with flat tax credit	No change
Health Savings Accounts (HSAs)	People can put unused portion of the tax credit in an HSA	No provision
Insurance Market Regulation	De-regulation: Permits sale of insurance across state lines	Guaranteed issue with no health status rating
Insurance Marketplace	Establish high-risk pools for the "uninsurable"	Individuals and small firms may take coverage through exchange
Minimum Benefits Package	None	FEHBP level benefits
Impact on Current Employer Insurance Market	Retained	Retained; small employers may participate in the new exchange
Impact on Non-Group Market	Establishes a "Guaranteed Access Plan" for the uninsurable	Current market is retained and competes for enrollment with the exchange
Public Plan	No public plan	Private carriers compete with public plan
System-wide Risk Adjustment	None	None
Guaranteed Issue	No, establishes plan for uninsurable	Yes, both in and out of the exchange.
Minimum Loss Ratios	None specified	Yes in "non-competitive areas." Minimum not specified

One of the sharpest distinctions between the candidates' plans is the approach taken to insurance market regulation. The Obama plan requires insurers to issue coverage to all applicants and prohibits the use of health status in setting premiums. This would have the effect of increasing premiums for younger and healthier people while reducing premiums for older and sicker people.<sup>5</sup>

The McCain plan would have the opposite effect on premiums by permitting the sale of insurance across state lines. Currently, some states prohibit or limit the use of health status and other risk factors in setting premiums. Under the McCain plan, individuals and firms in these states would be able to purchase insurance from insurers in other states where there are few such restrictions, thus effectively deregulating much of the insurance market. It would similarly reduce the effectiveness of states' guaranteed issue and mandatory benefits requirements as well as the more rigorous consumer protection and fair marketing practices requirements imposed by some states.

This deregulation would tend to result in lower premiums for younger and healthier people while tending to increase premiums for older and sicker people. The McCain plan establishes a federally subsidized high-risk pool called the Guaranteed Access Plan (GAP) that would provide coverage to those denied coverage due to health status.

Both plans include features designed to reduce spending throughout the health system. The McCain plan is intended to lower premiums by avoiding state minimum benefits laws. It would also reduce premiums in the non-group market by providing federal subsidies to high-risk pools.<sup>6</sup> The Obama plan would reduce premiums by providing a premium tax credit to small employers, establishing a federally subsidized re-insurance program for employer plans with catastrophic losses for individual beneficiaries.

Both candidates propose steps to improve the delivery of coordinated care, disease management, funding for health information technology (HIT) and comparative effectiveness reviews and research. However, the Obama plan is more specific as to funding and requirements for public and private insurers to adopt their use, which as discussed above, we used in setting our assumptions concerning their cost savings effects.<sup>7</sup>

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<sup>5</sup> The Campaign has not specified whether insurers would be able to adjust premiums for smoker status or other behavioral factors.

<sup>6</sup> High-risk pools do not apply to the employer market, because under the Health Insurance Portability and Accountability Act (HIPAA), employer plans are required to guarantee issue insurance to people who have maintained coverage for the prior 12 months regardless of health status.

<sup>7</sup> The Obama proposal specifies the amount of funding for HIT and requires the use of chronic care management and payment methods for Medicare, FEHBP and the National Exchange. The McCain plan specifies changes in payment policy under public programs for "high quality disease care."

## B. Changes in Sources of Insurance Coverage

There will be an average of about 48.9 million people without insurance at any point in time during 2010 (*Figure 2*).<sup>8</sup> The McCain plan would reduce the number of uninsured by about 21.1 million people. This reflects the impact of the tax credits, the federally subsidized GAP high-risk pools and changes in premiums due to cross-state sale of insurance.

**Figure 2:**  
Changes in Primary Source of Health Insurance for Americans: 2010<sup>a/</sup>  
(millions)

		The McCain Plan		The Obama Plan	
	Current Law	Change	Number	Change	Number
Private Employer Coverage	157.4	-9.4	148.0	-13.9 <sup>b/</sup>	143.5
<i>Employer Buy-in to New Public Plan<sup>c/</sup></i>	-	-	-	18.6 <sup>b/</sup>	18.6
Non-group Coverage	14.2	23.9	38.1	-7.7	6.5
<i>Individual Buy-in to New Public Plan</i>	-	-	-	13.1	13.1
<i>New High-Risk Pool</i>	-	5.8	5.8	-	-
Medicaid/SCHIP Traditional <sup>d/</sup>	41.5	-11.2	30.3	16.6	58.1
<i>Medicaid Opt-out for Private Coverage</i>	-	12.0	12.0	-	-
Medicare <sup>c/</sup>	38.9	-	38.9	-	38.9
TRICARE/Military	6.0	-	6.0	-	6.0
Uninsured	48.9	-21.1	27.8	-26.6	22.3
Total Population	307.0	N/A	307.0	N/A	307.0
<b>Public/Private Coverage</b>					
Number with Public Coverage	86.4	-5.4	81.0	48.3	134.7
Number with Private Coverage	171.6	26.5	198.1	-21.6	150.0

a/ Assumes both plans are fully implemented in 2010.

b/ There is a net increase of 4.7 million people in the number of workers and dependents in a firm purchasing coverage for their workers. These include 18.6 million people whose employer buys them coverage through the new National Plan, less a decline in the number of employers purchasing private insurance of 13.9 million people.

c/ Includes workers and dependents in small firms where the employer purchases coverage for their workers in the public plan.

d/ Medicaid recipients also covered under Medicare are counted with Medicare and are not included in this line. Eligible but not enrolled people are not counted as covered under Medicaid or SCHIP.

Source: The Lewin Group estimates.

Most of this increase in coverage under the McCain plan would result from people purchasing non-group coverage in the individual market with the help of the credit. Medicaid enrollment would remain virtually unchanged. However, about 12.0 million Medicaid recipients would elect the newly created option to enroll in a private health insurance plan using the tax credit and Medicaid funding.

<sup>8</sup> This is based on the 2007 Current Population Survey, which we corrected for under-reporting of Medicaid coverage and projected to 2010. About 36.2 million people will be uninsured for the entire year and 65.4 million people will be uninsured at some point in the year.



The Obama plan would reduce the number of uninsured by about 26.6 million people. The number of people on Medicaid or SCHIP would increase by 16.6 million people, most of which is attributed to expansions in eligibility for Medicaid under the plan. The remainder would be primarily people who use premium subsidies to purchase individual insurance and the mandate for parents to enroll eligible children.

The number of people with private ESI would decline by about 9.4 million people under the McCain plan. This loss of coverage occurs because the McCain plan substantially reduces the relative cost advantage of ESI by allowing the tax credit to be used for non-group insurance and eliminating the income tax exclusion for employer benefits. Also, the federal subsidy of the high-risk pools effectively reduces the cost of non-group coverage by removing many high-cost people with chronic conditions from the non-group market risk pool. Thus, there often would be cases where it is less costly for an employer's workforce to obtain coverage in the individual market, despite higher administrative costs, than to cover them under ESI.<sup>9</sup> The number of people with private non-group coverage would increase by 23.9 million people. About 5.8 million people would enroll in the GAP high-risk pool.

The Obama plan requires employers to provide insurance or pay a tax, which we assumed to be set at about 6.0 percent of wages and salaries.<sup>10</sup> We estimate that at this tax rate, some employers would find it less costly to provide insurance, resulting in an additional 4.7 million workers and dependents with ESI. However, many small employers would take the option of purchasing coverage for their workers under the national public plan.

Though not fully specified, the National Plan could have a significant cost advantage over private insurance. Provider payment levels under nearly all government sponsored programs are substantially lower than in private insurance. For example, Medicare payments to hospitals are about 22 percent less than what private insurers pay for comparable services. Government plans also do not have an allowance for profit and marketing (except for contracted services) as in private insurance.

For illustrative purposes, we estimate that premiums under the new National Plan would set payment levels at the midpoint between Medicare and private payer payment levels. Consequently, the number of people with private employer insurance would decline by about 13.9 million people. Eligible small employers would cover an additional 18.6 million workers and dependents under the National Plan. Another 13.1 million people would take coverage as individuals under the National Plan.

The number of people with public coverage would increase by 48.3 million people under the Obama plan, including Medicaid and the new National Plan. Public coverage would decrease by 5.4 million people under the McCain plan, which is net of enrollment in the new high-risk pools. This includes primarily Medicaid enrollees who would be enrolled by states in private

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<sup>9</sup> We estimate that non-group premiums under the McCain plan would be reduced up to 12 percent by segmenting these high-cost people from the individual market.

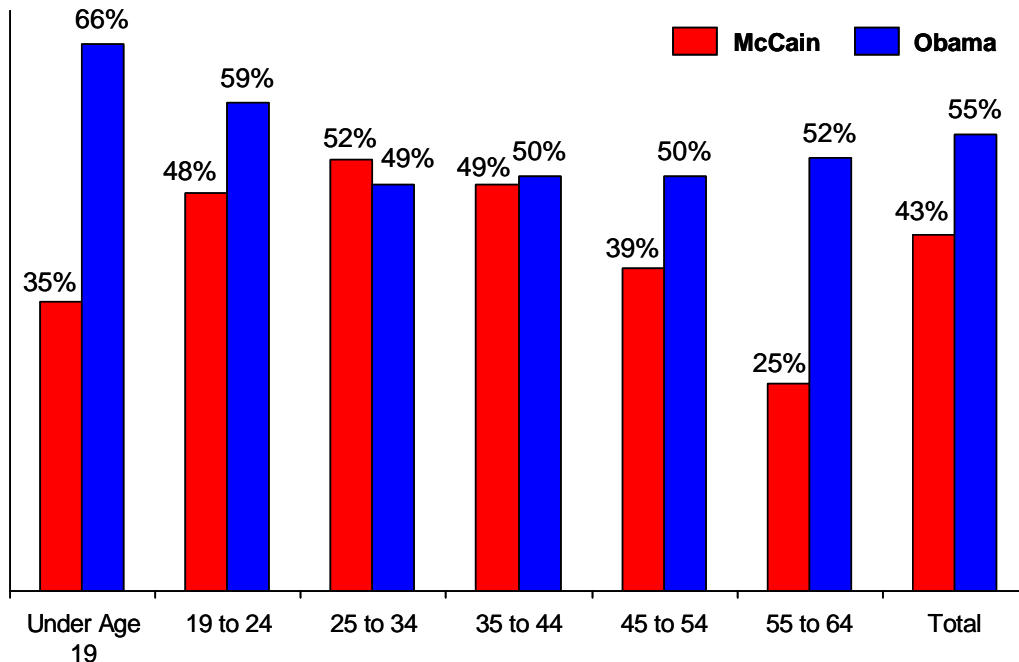
<sup>10</sup> We specified the tax rate because the Obama campaign has not yet specified this parameter. Six percent is equal to about half of the employer contributions for insurance as a percentage of worker payroll (about 12.0 percent) in firms that are now offering insurance.

insurance with the aid of the federal tax credit. Private coverage would increase by 26.5 million people under the McCain plan and decreases by 21.6 million people under the Obama proposal.

### C. Coverage for the Uninsured

The McCain plan would reduce the number of uninsured by about 43 percent, while the Obama plan would reduce the number of uninsured by about 55 percent (*Figure 3*).

**Figure 3**  
Percent Reduction in Uninsured under Candidates' Plans by Age: 2010<sup>a/</sup>



a/ Assumes both plans are fully implemented in 2010.

Source: The Lewin Group estimates.

#### 1. Coverage by Age

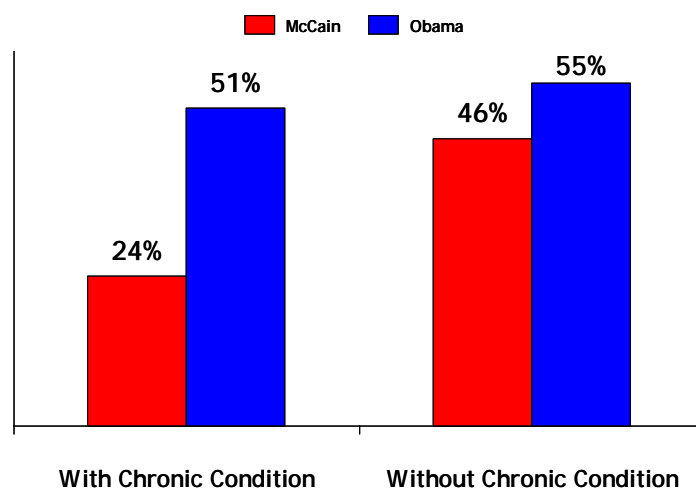
The Obama plan covers about 66 percent of all uninsured children compared with 35 percent under the McCain plan. This reflects the Obama plan's mandate for covering children. Although the Obama plan specifies no penalties for parents who fail to cover their children, the campaign does suggest that the mandate could be enforced through the schools. However, we have assumed that the lack of a penalty would diminish compliance.

The percentage of adults taking coverage under the McCain plan would generally fall in older age groups. Only about 25 percent of the uninsured between the ages of 55 and 64 become covered under the McCain plan, compared with about 52 percent for this age group under the Obama plan. This reflects that cross-state sale of insurance under the McCain plan would tend to increase premiums for older and sicker people, many of whom are concentrated in this age group. By contrast, the Obama plan prohibits the use of health status in setting premiums, which would cause more people in this age.

## 2. Coverage for the Chronically Ill

As shown in *Figure 4*, only about 24 percent of the uninsured with a chronic health condition would become covered under the McCain plan, compared with about half of this group under the Obama plan.

**Figure 4**  
Percentage Reduction (Increase) in the Number of People with a Chronic Health Condition Who Are Uninsured<sup>a/</sup>



a/ Assumes both plans are fully implemented in 2010.  
Source: The Lewin Group estimates.

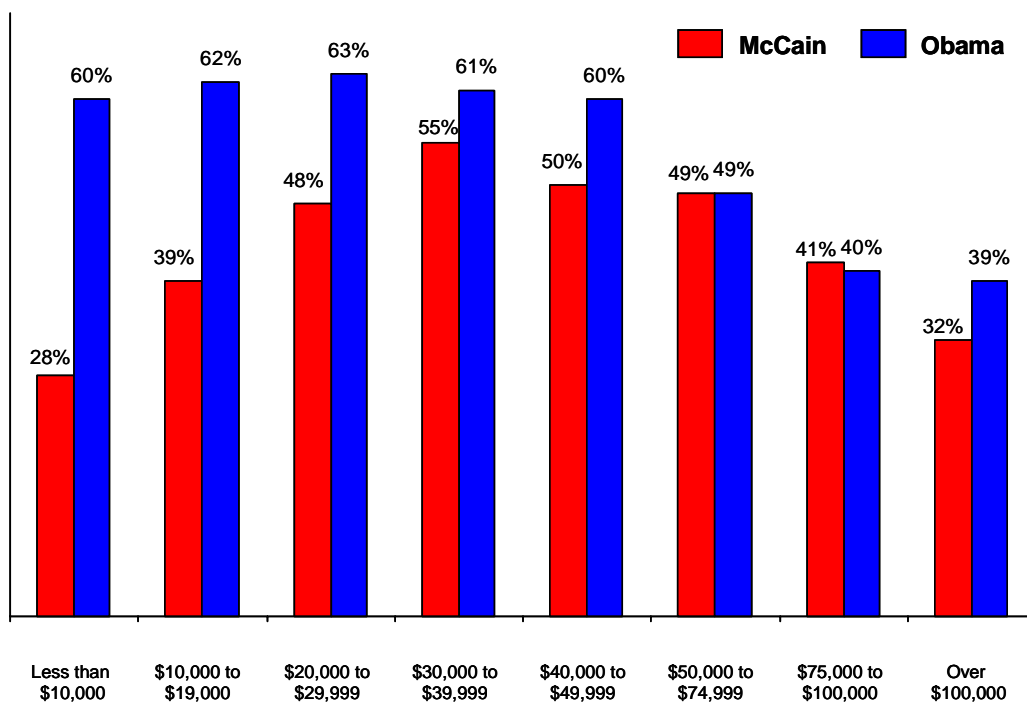
## 3. Coverage by Income Level

The Obama plan would be more effective in covering the low-income uninsured. For example, the Obama plan would cover 60 percent of the uninsured with incomes under \$10,000, compared with only 28 percent taking coverage under the McCain plan (*Figure 5*). This is because Medicaid coverage under Obama's plan does not require a premium and will be affordable to the newly eligible.

Under the McCain plan, younger and healthier people will often be able to obtain coverage for the amount of the tax credit. In fact, some insurers are likely to aggressively market policies to this group, which would be at no cost to the individual. However, this would occur primarily among lower-cost individuals. Older and less healthy people would tend to face much higher premiums that would be only partially covered by tax credit. These people are not likely to be able to afford the added amount that would be required to obtain the insurance, resulting in lower overall enrollment among lower-income groups in particular.

The distribution of newly insured people by income tends to differ across the two plans. About 28 percent of newly insured people under the Obama plan (7.3 million) would have incomes of \$20,000 or less, while only about 20 percent of newly insured people under the McCain plan (4.3 million) would be in this income group (*Figure 6*). By contrast, about 36 percent of newly insured people under the McCain plan (7.5 million) would have incomes of \$50,000 or more, compared with only about 30 percent of newly insured people under the Obama plan.

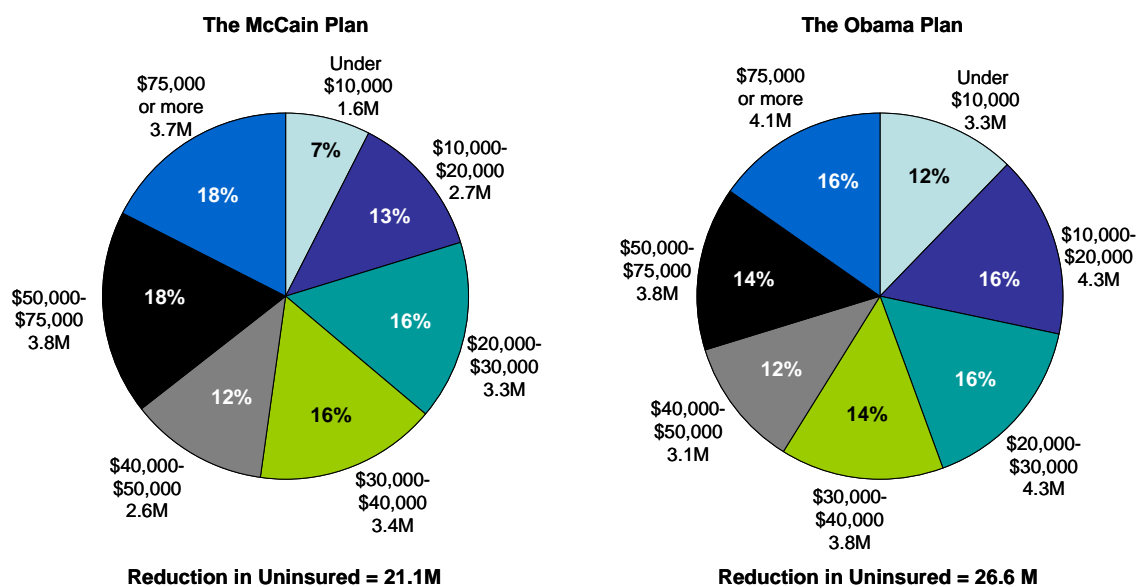
Figure 5  
Percent Reduction in Uninsured under Candidates' Plans by Family Income: 2010<sup>a/</sup>



a/ Assumes both plans are fully implemented in 2010.

Source: The Lewin Group estimates.

Figure 6  
Reduction in Uninsured under Candidates' Plans by Family Income: 2010<sup>a/</sup>  
(millions)



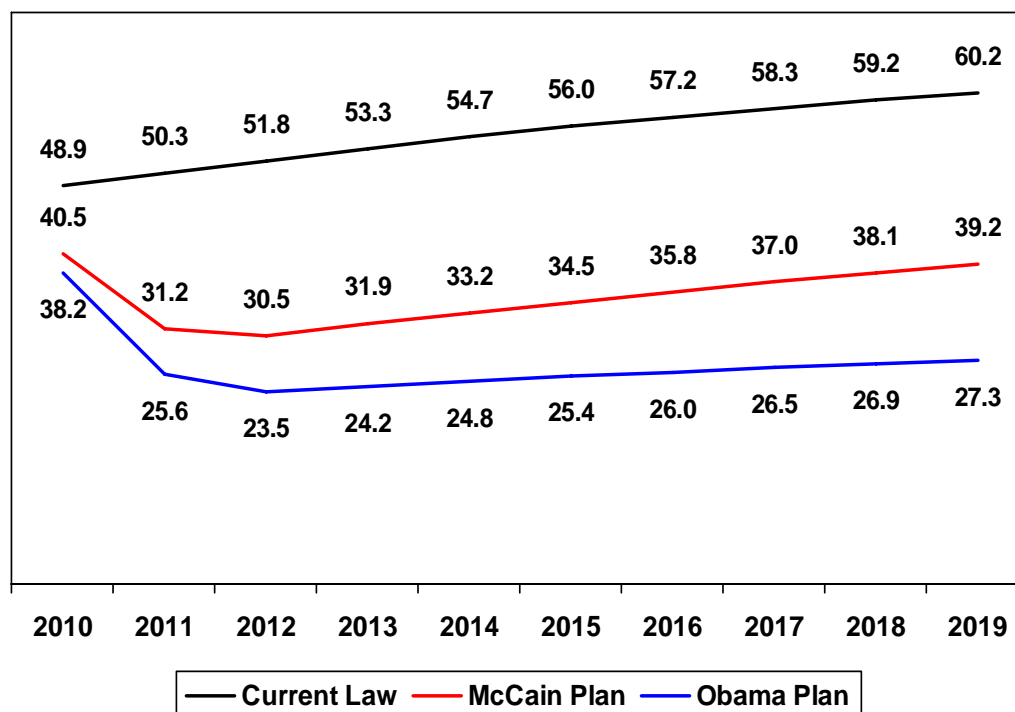
a/ Assumes both plans are fully implemented in 2010.

Source: The Lewin Group estimates.

#### 4. Long Term Effects on Coverage

We estimate that under current trends, the number of uninsured in the US will grow from 48.6 million people in 2010 to 60.2 million people by 2019, which is partly due to simple population growth (*Figure 7*). However, it also reflects continuation of the historical trend towards reduced coverage attributed largely to the continued growth in health care costs relative to income. As discussed above, we estimate that if fully implemented in 2010, the McCain plan would reduce the number of uninsured by 21.1 million people while the Obama plan would reduce the number of uninsured by 26.6 million people.

Figure 7  
Projected Number of Uninsured under Current Law, the Obama Plan and the McCain Plan:  
2010 - 2019  
(millions)



Source: The Lewin Group estimates.

However, our long-term estimates of coverage under the McCain and Obama plans reflect expected lags in public awareness of program eligibility that will delay the full effect of these programs on coverage. Based upon experience with prior coverage expansions, we assume that it would take up to three years for the programs to reach their expected levels of enrollment.

Under the Obama plan, the uninsured population would be reduced by about 54 percent throughout the next decade once fully implemented. However, the number of uninsured would still increase over time under the Obama plan due to population growth and the strain of continued increases in health spending over this period. We estimate that the Obama plan would reduce the number of uninsured to 23.5 million people in 2012, with the number of uninsured growing to 27.3 million people by 2019.

The number of uninsured would grow at a faster rate under the McCain plan. This is because the amount of the tax credit would be indexed annually by the consumer price index (CPI), which is less than half the expected rate of growth in health care costs. Thus, the cost of insurance would grow faster than the amount of the credit, thus eroding the buying power of the tax credit. This would result in some the loss of the initial coverage gains under the McCain plan.

Consequently the 41 percent reduction in the uninsured occurring in 2012 under the McCain plan will diminish to a 35 percent reduction in the uninsured by 2019. By 2019, there would still be 39.2 million uninsured people in the US under the McCain plan.

## D. Impact on National Health Spending

Both the McCain and Obama health reform plans include initiatives and features designed to reduce the growth in health care costs. The Office of the Actuary (OAct) of the Centers for Medicare and Medicaid Services (CMS) estimates that national health spending will reach \$2.73 trillion in 2010.<sup>11</sup> This includes all expenditures for health services by all payers including governments, employers and consumers.

Per capita health expenditures have grown at a rate of about 7.9 percent over the 2001 through 2006 period, compared with per-capita growth in gross domestic product (GDP) of only about 4.2 percent over that same period. The percentage of workers in firms offering health insurance declined from 68 percent in 2001 to 60 percent in 2006.<sup>12</sup> In fact the number of uninsured has grown by up to 1 million people per year over the same time frame. Therefore, simply maintaining current coverage levels would require controlling costs.

The McCain and the Obama proposals would actually reduce national health expenditures by \$42.0 billion and \$54.1 billion respectively over the 2010 through 2019 period (*Figure 8*). While this is merely a fraction of total health spending over the 10-year period (\$37.0 trillion), it is notable given that both candidates would substantially increase the number of people with insurance coverage.

Utilization of health services for newly insured people under the McCain plan would increase by about \$171.6 billion over the 10-year period (2010-2019), compared with an increase of \$475.1 billion under the Obama plan.<sup>13</sup> The spending increase is larger for the Obama plan because it covers more people across all age and health status groups. By contrast, the McCain plan tends to cover relatively younger and healthier people who would have lower health care costs.

Providers will see, on average, a small increase in provider reimbursement levels of \$131.8 billion under the McCain's plan, and \$105.0 billion under the Obama plan. This is largely due to a reduction in the amount of care provided free by providers resulting from a reduction in the uninsured population.

Insurer administrative costs would increase by about \$87.1 billion under the McCain plan, reflecting the cost of administering coverage to 21 million newly insured people. Administrative costs would decline by about \$62.7 billion under the Obama plan, because coverage is expanded through government programs, in which administrative costs are lower than under private coverage. Also, there would be a small reduction in administrative costs for people taking coverage through the National Exchange under the Obama plan.

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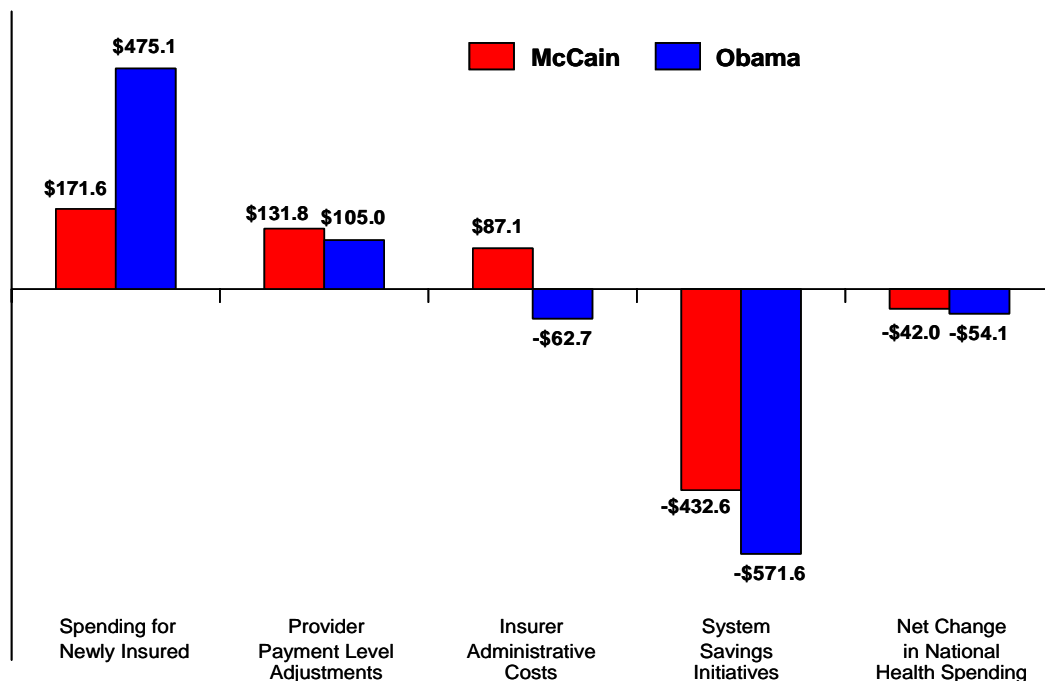
<sup>11</sup> National Health Expenditures Accounts, Office of the Actuary (OAct) of the Centers for Medicare and Medicaid Services.

<sup>12</sup> "Employer Health Benefits: 2006 Annual Survey," The Kaiser Family Foundation (KFF) and the Health Research and Educational Trust.

<sup>13</sup> We assume that health services utilization for newly insured people would adjust to levels reported by insured people with similar age, gender, income and health status characteristics, resulting in an overall increase in health services utilization.



Figure 8  
Summary of Changes in National Health Spending Under the McCain and the Obama Proposals:  
2010-2019 <sup>a/</sup>  
(billions)



a/ Estimates reflect changes in all spending for health care including premium payments and out-of-pocket spending.

Source: The Lewin Group estimates.

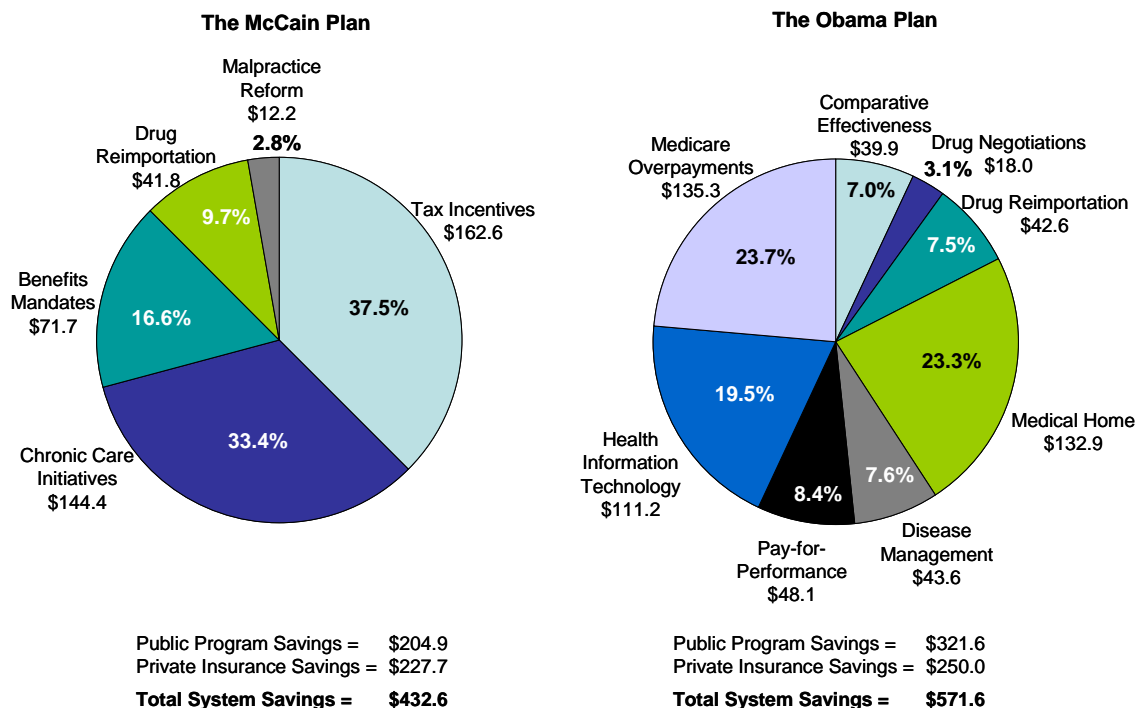
Cost containment features in both candidates' plans would result in substantial savings. Cumulative system savings during 2010-2019 would be about \$432.6 billion under the McCain plan and \$571.6 billion under the Obama plan. We present a detailed analysis of these provisions for both candidates' plans in *Appendices A and B*.

The most significant system savings features under the McCain plan include:

- **Tax incentives:** By making employer health benefits taxable, consumers will have a new incentive to seek out lower-cost coverage. This would stimulate increased price competition among insurers resulting in increased enrollment in more efficient and lower cost-coverage. Savings would be \$162.6 billion (*Figure 9*).
- **Reduced mandated benefits costs:** By permitting the sale of insurance across state lines, individuals and employers would have the option of purchasing coverage without the benefits mandates found in many states. For many consumers, many of these mandated benefits would be purchased voluntarily regardless of the state benefits mandates. Based upon analyses of this issue by the Congressional Budget Office (CBO), we assumed savings would be up to 5 percent for people in affected markets. Total savings would be \$71.7 billion.

- **Drug re-importation:** The proposal calls for safe re-importation of drugs from other countries resulting in savings to Medicare and private health insurance. Ten-year savings would be \$41.8 billion. Estimates were derived from CBO analyses.

Figure 9  
Reduction in National Health Spending under System Saving Provisions of the McCain and Obama Proposals (billions)



Source: The Lewin Group estimates.

- **Malpractice reform:** This provision would eliminate lawsuits directed at physicians who follow clinical guidelines and adhere to safety protocols. Based on the outcomes of measures implemented in some states to reduce frivolous claims, we estimate savings of about \$12.2 billion over 10 years.
- **Coordination of care for the chronically ill:** The McCain proposal includes a focus on chronic care for people in Medicare. His plan would change Medicare payment systems to compensate providers for diagnosis, prevention and care coordination that would be based upon the “pay-for-performance” model. It would also direct federal research to focus on care of chronic illness. Based upon estimates of savings from primary care case management systems where used, we estimate total savings of \$144.4 billion for Medicare under this provision.
- **Health information technology (HIT):** The McCain proposal states that it would promote rapid development of health information technology (HIT). However, there is no indication of how much federal funding would be provided and the methods of promotion are not explained. For these reasons, we were not able to estimate savings from HIT.

The Obama proposal also includes several initiatives to control costs. The most significant of these include:

- **Institute for comparative effectiveness:** Senator Obama would “establish an institute to guide reviews and research on comparative effectiveness so that Americans and their doctors will have accurate and objective information to make the best decisions for their health and well-being.” The Institute would research the relative effectiveness of alternate treatments and promulgating evidence-based guidelines. Because there is overwhelming evidence of poor adherence to existing medical guidelines, we estimate that savings from this proposal would be only about \$39.9 billion, which is the savings net of Institute operations and research spending.<sup>14</sup>
- **Fund health information technology (HIT):** The Obama proposal would provide \$10.0 billion in funding each year for five years to expand the use of HIT that reduces provider costs and facilitates improved health outcomes. Because HIT is already expected to be widely implemented under current trends, most of the expected savings will occur without government intervention. The added savings from accelerating the adoption of HIT would be \$111.2 billion over ten years, net of the \$50 billion that would be invested by the federal government.
- **Medicare overpayments:** The payment levels for Medicare advantage plans are estimated to be up to 12 percent higher than what participating beneficiaries would cost under the Medicare fee-for-service program. Savings to Medicare from eliminating these overpayments would be \$135.3 billion.
- **Prescription drug price negotiation:** The Obama proposal would authorize the Secretary of the Department of Health and Human Services (HHS) to negotiate prescription drug prices directly with drug manufacturers for Part D of Medicare. The Congressional Budget Office estimates that this is not expected to reduce costs except for single-source drugs with no therapeutic alternative. We estimate savings would be \$18 billion over 10 years.
- **Drug re-importation:** The Obama proposal provides for safe re-importation of drugs from other countries resulting in savings to both Medicare and private health insurance. Ten-year savings would be \$42.6 billion. This estimate was derived from CBO analyses.
- **Disease management (DM):** The Obama proposal would require the use of DM programs in Medicare, the new National Exchange and the Federal Employees Health Benefits Program (FEHBP). However, extensive research in this area has failed to establish that DM reduces costs, although there is evidence of improved health outcomes. The most evidence for savings was in treatment for patients with diabetes and cardiac conditions. Based on this, we estimate potential savings of about \$43.6 billion over the 10-year period.
- **Medical home:** The Obama plan supports the use of the medical home model to coordinate the care provided to patients being treated for multiple health conditions. Because the proposal does not specify how this would be implemented, we modeled it

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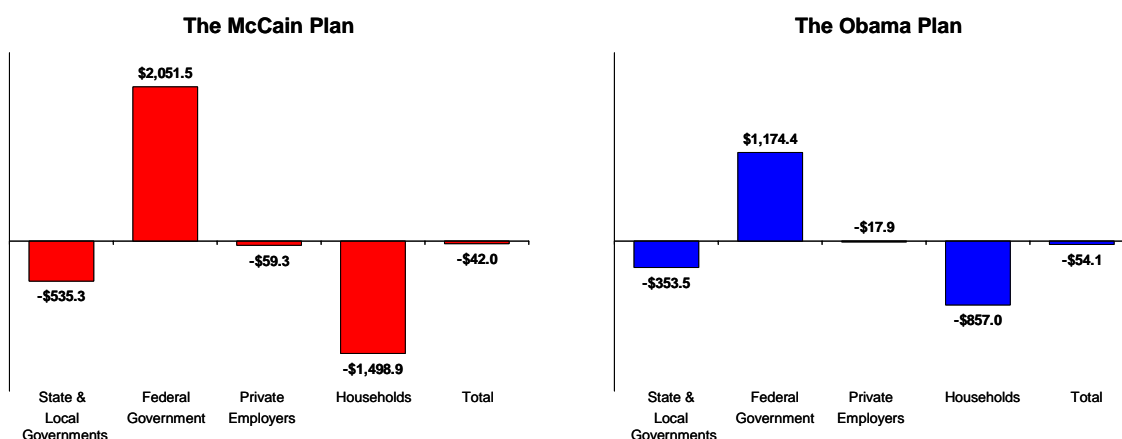
<sup>14</sup> We have estimated that savings could be dramatically larger if financial incentives were introduced to encourage physicians and patients to adhere to guidelines.

assuming that participation would be optional. Savings would be \$132.9 billion over the 2010 through 2019 period.

- **Pay-for-performance:** The plan would require adoption of the pay-for-performance model under Medicare, FEHBP and plans in the new National Exchange. For illustrative purposes, we assumed that the Obama plan will expand the CMS Premier Hospital Quality Incentive Demonstration (HQID) to apply to all acute care hospitals.<sup>15</sup> We estimate savings of about \$48.1 billion over 10 years based on this model.

Figure 10 presents our estimates of changes in total health spending for the four major payer groups, including the federal government, state governments, private employers and households. We discuss these impacts for each payer group in the following sections.

**Figure 10**  
Ten-Year Changes in Health Spending by Payer Group Compared: 2010-2019<sup>a</sup>  
(billions)



a/ Reflects expected wage effects from employer savings.  
Source: The Lewin Group estimates.

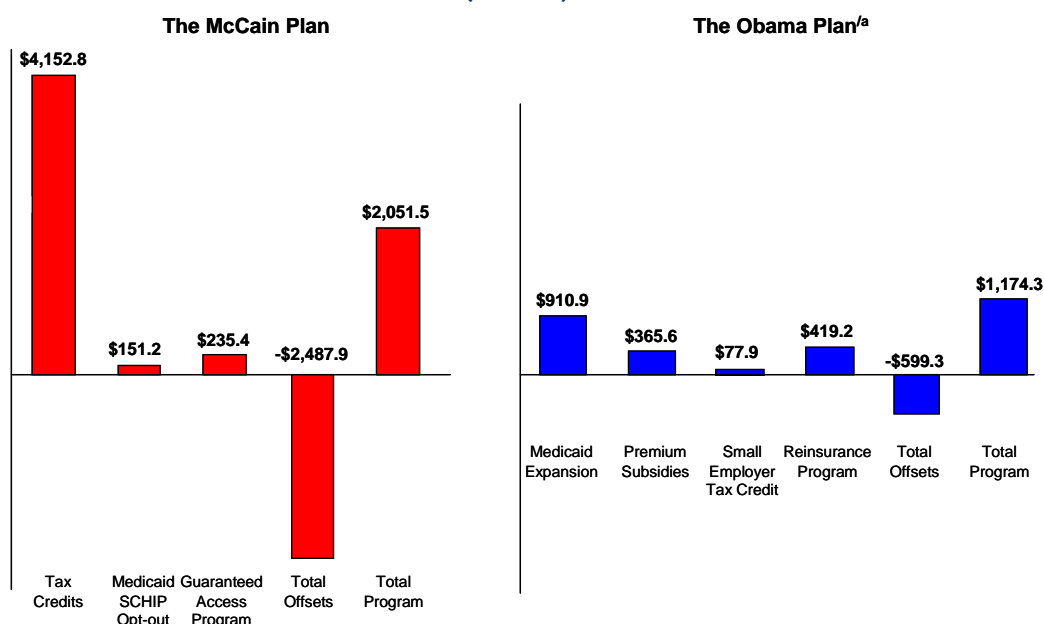
<sup>15</sup> Premier is a nationwide association of not-for-profit hospitals.

## E. Federal Spending and Revenues

Both of the candidates' health reform plans would result in substantial increases in federal spending. The McCain proposal would increase federal health spending net of offsets by about \$2.05 trillion over the 2010 through 2019 period (*Figure 11*). The Obama plan would increase federal spending by about \$1.17 trillion over this same period.

The proposed tax credits under the McCain plan would cost \$4.15 trillion over ten years. The newly created option for states to cover Medicaid recipients under private insurance aided by the tax credit would cost about \$151.2 billion. Federal subsidies to the GAP high-risk pools would cost \$235.4 billion. There would be \$2.49 trillion in offsets under the proposal, most of which are attributed to revenues from taxing employer health benefits, resulting in a net increase in the federal deficit of \$2.05 trillion.

Figure 11  
Total Federal Health Spending for Candidate's Plans Compared: 2010-2019  
(billions)



a/ Net of federal funding for HIT.

Source: The Lewin Group estimates.

Key elements of new federal spending under the McCain plan include:

- Tax credits:** The tax credit for health insurance would be \$2,500 for individuals and \$5,000 for families who obtain private insurance through an employer or purchase private insurance as an individual in the non-group market. The McCain campaign has indicated that the tax credit would be indexed annually to the Consumer Price Index (CPI), which is less than half the projected rate of growth in health care costs over the projection period;<sup>16</sup>

<sup>16</sup> Statement by Jay Khosla, Health Policy Advisor for John McCain on September 18, 2008 conference at GWU.

- **Medicaid opt-out:** The McCain plan would permit states to use Medicaid funds to cover beneficiaries under private health insurance with the aid of the federally funded tax credit. Covering the first \$2,500 or \$5,000 of costs for these enrollees with a federally funded credit effectively increases the federal cost for participating Medicaid beneficiaries while reducing the amount paid by states (i.e., the state share of the cost in excess of the credit); and
- **Guaranteed Access Program (GAP):** Subsidies to high-risk pools under GAP would cost about \$471 billion over the ten years, half of which would be funded with an assessment on non-group insurance. The remaining half (\$235.4 billion) would be paid by the federal government.<sup>17</sup>

New spending under the Obama plan includes about \$910.9 billion for the Medicaid expansion and \$365.6 billion for premium subsidies. The small employer tax credits would cost \$77.9 billion and the reinsurance program for employers would cost about \$419.2 billion. Total offsets would be \$599.3 billion, leaving a net increase in the federal deficit of \$1.17 trillion for 2010 through 2019.

Key elements of new federal spending under the Obama plan include:

- **Medicaid expansion:** Because the details of the proposed Medicaid expansion are not available, we assumed that eligibility levels for adults under the program are increased to 150 percent of the FPL. We assumed that the cost of the expansion would be paid for by the federal government.<sup>18</sup>
- **Premium subsidies:** The Obama plan would provide premium subsidies for private insurance on a sliding scale based on income for people who do not have access to ESI. Because details of the program also are not available, we assumed that subsidies are available for people with incomes between 150 percent of the FPL and 400 percent of the FPL.
- **Small employer tax credit:** The Obama plan includes a tax credit for small employers equal to up to half of employer contributions for insurance. While the campaign does not specify the details of the credit, they have indicated that it would be structured to cost the federal budget no more than \$6.0 billion per year. We found that to remain within the \$6.0 billion budget, tax credits would need to be restricted to employers with fewer than ten lower wage workers.
- **Reinsurance program:** The campaign proposes a federally funded reinsurance program for all employers that would cover catastrophic costs for individual plan members. While none of the details are available, campaign advisors have indicated that they expect the plan to reduce employer costs by 4.0 percent. We estimate that a reinsurance plan resulting in this level of saving could be achieved by covering 75 percent of costs in excess of \$140,000 for each plan member.<sup>19</sup>

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<sup>17</sup> Communication with Douglas Holtz-Eakin, Senior Policy Advisor, McCain Campaign

<sup>18</sup> In our analyses of both proposals, we assume that the candidates do not mean to imply an “unfunded mandate” for state spending unless otherwise indicated.

<sup>19</sup> While earlier in the year the campaign did indicate that the plan would be restricted to small employers, the current campaign literature implies that it would be available to all employers.


### Exhibit 1 Two Key Design Elements in the McCain Plan

The McCain plan eliminates the current income tax exclusion for employer provided health benefits, but retains the exclusion for Social Security and Medicare payroll taxes. This retains a portion of the existing tax incentive for employers to providing employer-sponsored insurance (ESI). We estimate that about 16.1 million people who now have (ESI) would lose that coverage by eliminating the income tax portion of the exemption. The overall cost of the McCain program would be \$2.05 trillion over 2010 through 2019.

If the McCain plan is changed so that the payroll tax exclusion is also eliminated, federal tax revenues would increase by over \$1.1 trillion, thus reducing the net federal cost of the program to \$935 billion over the ten-year period. However, by eliminating the remaining tax incentive for ESI, the number of people losing ESI would increase to 26.9 million people. Because many of these people would not purchase non-group coverage, the reduction in the number of uninsured under the proposal would fall from 21.1 million people to 17.7 million people.

McCain campaign has specified that half of the cost of losses under the GAP high-risk pool would be financed with an assessment on all non-group coverage. The federal share of the costs would come from general revenues and constitutes a subsidy of the non-group market that actually reduces the cost of non-group coverage relative to employer coverage, which is one of the reasons for the loss of employer coverage. If the full amount of GAP program losses is paid by the federal government, average premiums in the non-group market would be 35 percent less than employer premiums, resulting in a total of 40.1 million people losing ESI.

#### Impact of McCain Plan under Variations on Elimination of the Payroll Tax Exclusion for Employer Provided Benefits and the Use of an Assessment to Fund GAP Losses

	With 50% Insurer Assessment for GAP		With No GAP Assessment	
	Eliminate Income Tax Exclusion Only	Eliminate both Income Tax and Payroll Tax Exclusion	Eliminate Income Tax Exclusion Only	Eliminate both Income Tax and Payroll Tax Exclusion
 McCain as specified				
People Losing their Employer Coverage	16.1 million	26.9 million	29.3 million	40.1 million
Net Reduction in Employer Coverage <sup>a/</sup>	9.4 million	17.5 million	23.2 million	30.7 million
Reduction in Uninsured	21.1 million	17.7 million	22.1 million	18.7 million
Guaranteed Access Plan Federal Subsidies 2010-2019 (i.e., Costs net of assessment revenues)	\$235 billion	\$291 billion	\$617 billion	\$764.2 billion
Net Federal Costs 2010-2019	\$2.05 trillion	\$935 billion	\$2.56 trillion	\$1.43 trillion

a/ Reflects increased coverage among uninsured eligible workers in existing plans due to the tax credit and firms that start to offer due to lower premiums resulting from cross-state sale of insurance.  
Source: The Lewin Group analysis using the Health Benefits Simulation Model (HBSM).



## Exhibit 2


### Changes in Public and Private Coverage under the National Public Plan Proposed by Senator Obama

The Obama Plan creates a new publicly operated National Plan that is available to individuals without access to employer coverage, the self employed and small employers (assumed to be firms with fewer than 25 workers). It is described as a public plan that would be offered as an alternative to the private health plans offered through the National Exchange.

The impact that the National Plan will have on insurance markets is largely dependent upon costs for the plan. Administrative costs are likely to be lower than in the private plans because there is no allowance for profit and there may be savings on broker and agent commissions. But the critical determinant of plan costs and premiums will be payment levels for health services.

In this study, we assumed that the public plan would adopt payment levels that are between the Medicare levels and the levels now paid by private payers. This reduces the premium by about 25 percent compared to private insurance premiums. Under this scenario, about 31.7 million people would enroll in the public plan. Total enrollment in public plans would increase by 48.1 million people, including those newly enrolled in Medicaid.

#### Impact of Using Medicare Provider Payment Levels in the National Plan Under the Obama Proposal in 2010

 Obama assumed	Midpoint Payment Levels: As Assumed	Medicare Payment levels	Private Payer Levels
Public Plan Premiums as a Percent of Private Insurance Premiums	-25 percent	-40 percent	-5 Percent
Reduction in Uninsured	26.6 million	28.0 million	24.3 million
Enrollment in National Public Plan	31.7 million	42.9 million	17.1 Million
Change in Public Coverage	48.3 million	60.1 million	28.4 million
Change in Private Coverage	-21.6 million	-32.0 million	-10.4 million

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

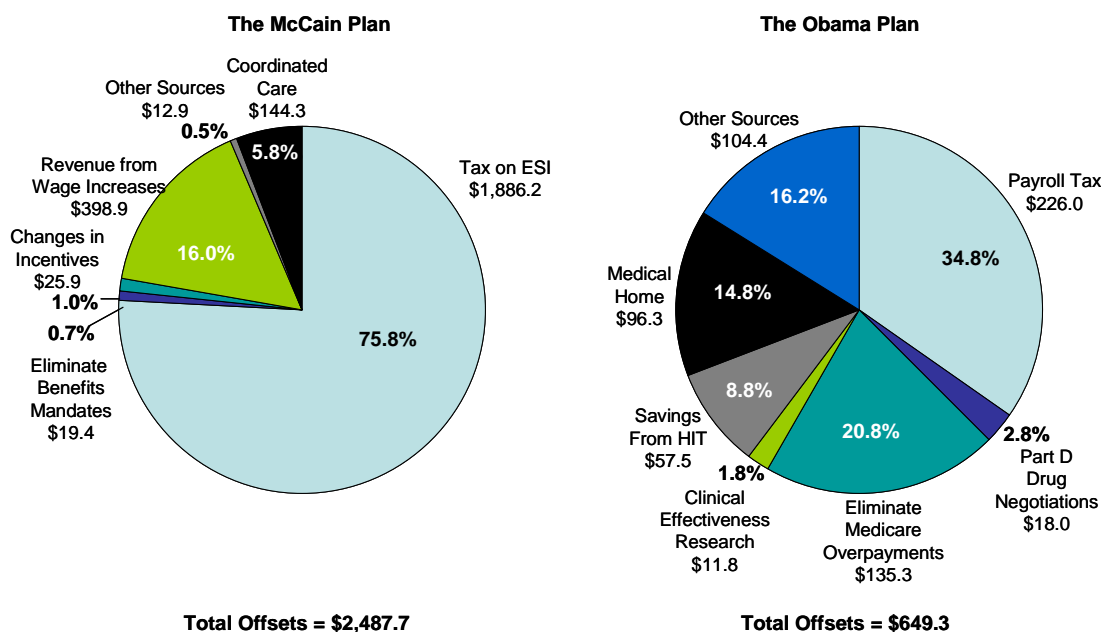
Premiums in the National Plan would be 40 percent lower than in the private market if Medicare payment levels are used. Under this scenario, enrollment in public coverage would increase to 60.1 million people. By contrast, we estimate that if private payer levels are used, premiums for the National Plan would be about 5 percent lower than in private plans resulting in total enrollment in the National Plan of about 17.1 million people.



The primary source of offsets to federal spending (\$2.49 trillion) under the McCain plan is revenues from requiring people to pay income tax on the value of health benefits provided by the employer (*Figure 12*). This results in \$1.88 trillion in new revenues, which is less than half of the new tax credit payments of \$4.15 trillion.<sup>20</sup> Other offsets under the McCain plan include \$398.9 billion in new tax revenues due to wage increases in firms that discontinue their health benefits. Medicare savings for chronic care coordination would be \$144.3 billion.

Spending offsets under the Obama plan (\$649.3 billion) include \$226.0 billion in tax payments by employers who do not offer health insurance. The federal share of savings from system-savings initiatives under the Obama plan (discussed above) would be \$423.3 billion, most of which would be for Medicare.

**Figure 12**  
Sources of Federal Offsets Under Candidates' Proposals: 2010-2019  
(billions)



Source: The Lewin Group estimates.

We present a detailed accounting of federal program spending and revenues under the McCain and Obama health plans in *Figures 13* and *14*.

<sup>20</sup> Tax revenues could be increased by roughly \$1.0 trillion by eliminating the tax exclusion for Social Security and Medicare payroll taxes.

**Figure 13**  
**Net Impact of the McCain Plan on Federal Health Spending: 2010-2019 (billions)**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
<b>Program Costs</b>												
Tax Credits	\$330.4	\$359.5	\$382.9	\$395.2	\$407.9	\$421.0	\$434.5	\$448.5	\$462.9	\$477.7	\$1,875.8	\$4,120.4
Net Change in Medicaid and SCHIP Spending	\$0.4	\$0.9	\$1.3	\$1.3	\$1.4	\$1.5	\$1.6	\$1.7	\$1.8	\$2.0	\$5.3	\$13.9
Medicaid Op-out to Private Insurance	\$2.2	\$9.7	\$16.3	\$16.2	\$16.1	\$15.7	\$15.6	\$15.5	\$15.1	\$14.9	\$60.5	\$137.3
Guaranteed Access Plan (GAP)- High-Risk Pool Subsidy	\$7.4	\$15.7	\$20.9	\$22.3	\$23.8	\$25.4	\$27.1	\$28.9	\$30.9	\$33.0	\$90.1	\$235.4
Administration of Tax Credits and Subsidies	\$2.2	\$2.5	\$2.7	\$2.9	\$3.1	\$3.3	\$3.5	\$3.8	\$4.0	\$4.3	\$13.4	\$32.4
<b>Total Costs</b>	<b>\$342.6</b>	<b>\$388.3</b>	<b>\$424.1</b>	<b>\$437.9</b>	<b>\$452.3</b>	<b>\$466.9</b>	<b>\$482.3</b>	<b>\$498.3</b>	<b>\$514.7</b>	<b>\$531.9</b>	<b>\$2,045.2</b>	<b>\$4,539.4</b>
<b>Revenues</b>												
Revenue From Tax on ESI	\$117.3	\$134.1	\$150.2	\$163.1	\$177.2	\$192.4	\$209.0	\$227.2	\$247.1	\$268.6	\$741.8	\$1,886.2
Effect of New Incentives on Other Federal Programs	\$0.7	\$1.4	\$1.9	\$2.1	\$2.2	\$2.3	\$2.5	\$2.7	\$2.9	\$3.1	\$8.3	\$21.8
Tax Revenue on Wage Effects	\$23.4	\$28.5	\$31.9	\$34.6	\$37.6	\$40.9	\$44.4	\$48.2	\$52.5	\$57.0	\$156.0	\$398.9
<b>Total Revenues</b>	<b>\$141.4</b>	<b>\$164.0</b>	<b>\$183.9</b>	<b>\$199.8</b>	<b>\$217.0</b>	<b>\$235.6</b>	<b>\$255.9</b>	<b>\$278.2</b>	<b>\$302.4</b>	<b>\$328.8</b>	<b>\$906.1</b>	<b>\$2,306.9</b>
<b>Offsets To Federal Programs due to Cost Containment Features</b>												
Drug Re-importation	\$0.7	\$0.7	\$0.8	\$0.9	\$1.0	\$1.1	\$1.2	\$1.2	\$1.3	\$1.4	\$4.1	\$10.3
Malpractice Reform	\$0.0	\$0.1	\$0.2	\$0.3	\$0.3	\$0.3	\$0.3	\$0.4	\$0.4	\$0.4	\$0.9	\$2.7
Tax Incentives	\$0.2	\$0.2	\$0.3	\$0.3	\$0.4	\$0.4	\$0.5	\$0.5	\$0.6	\$0.7	\$1.4	\$4.1
Mandatory benefits savings	\$1.4	\$1.5	\$1.7	\$1.8	\$1.8	\$2.0	\$2.1	\$2.3	\$2.4	\$2.6	\$8.2	\$19.6
Medicare Chronic Care pgms.	\$0.3	\$2.0	\$6.0	\$14.3	\$15.5	\$16.9	\$19.1	\$21.5	\$23.4	\$25.3	\$38.1	\$144.3
<b>Total Cost Containment</b>	<b>\$2.6</b>	<b>\$4.5</b>	<b>\$9.0</b>	<b>\$17.6</b>	<b>\$19.0</b>	<b>\$20.7</b>	<b>\$23.2</b>	<b>\$25.9</b>	<b>\$28.1</b>	<b>\$30.4</b>	<b>\$52.6</b>	<b>\$180.8</b>
<b>Total Net Federal Spending</b>												
Total New Program Spending	\$342.6	\$388.3	\$424.1	\$437.9	\$452.3	\$466.9	\$482.3	\$498.3	\$514.7	\$531.9	\$2,045.2	\$4,539.4
<b>Spending Net of Offsets</b>	<b>\$198.6</b>	<b>\$219.8</b>	<b>\$231.2</b>	<b>\$220.5</b>	<b>\$216.3</b>	<b>\$210.6</b>	<b>\$203.2</b>	<b>\$194.2</b>	<b>\$184.2</b>	<b>\$172.8</b>	<b>\$1,086.4</b>	<b>\$2,051.5</b>

Source: The Lewin Group estimates.

Figure 14  
Net Impact of the Obama Plan on Federal Health Spending: 2010-2019  
(billions)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
<b>Medicaid and SCHIP Coverage Expansion</b>												
Shift to Employer Plans	-\$4.7	-\$6.9	-\$8.2	-\$8.7	-\$9.3	-\$9.9	-\$10.6	-\$11.3	-\$12.0	-\$12.8	-\$37.8	-\$94.3
Children's Coverage	\$5.0	\$6.7	\$7.1	\$7.6	\$8.2	\$8.8	\$9.4	\$10.0	\$10.8	\$11.5	\$34.6	\$85.0
Expansion for Parents	\$5.4	\$11.5	\$15.4	\$16.4	\$17.5	\$18.6	\$19.8	\$21.2	\$22.6	\$24.0	\$66.2	\$172.4
Non-custodial Adults	\$23.5	\$50.0	\$66.7	\$71.1	\$75.8	\$80.8	\$86.1	\$91.8	\$97.8	\$104.3	\$287.0	\$747.8
<b>Total Medicaid</b>	<b>\$29.1</b>	<b>\$61.3</b>	<b>\$81.0</b>	<b>\$86.4</b>	<b>\$92.1</b>	<b>\$98.2</b>	<b>\$104.8</b>	<b>\$111.7</b>	<b>\$119.2</b>	<b>\$127.1</b>	<b>\$349.9</b>	<b>\$910.9</b>
<b>Other Proposed Programs</b>												
Premium Subsidy Program <sup>a/</sup>	\$11.4	\$24.4	\$32.6	\$34.7	\$37.0	\$39.5	\$42.1	\$44.9	\$47.9	\$51.1	\$140.1	\$365.6
Small Employer Tax Credits	\$3.6	\$5.8	\$6.8	\$7.2	\$7.7	\$8.2	\$8.8	\$9.3	\$9.9	\$10.6	\$31.1	\$77.9
Reinsurance Program	\$28.2	\$33.3	\$35.5	\$37.8	\$40.3	\$42.9	\$45.7	\$48.6	\$51.8	\$55.2	\$175.1	\$419.2
National Plan Net Cost	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Funding for HIT	\$10.0	\$10.0	\$10.0	\$10.0	\$10.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$50.0	\$50.0
<b>Total Programs</b>	<b>\$53.2</b>	<b>\$73.5</b>	<b>\$84.9</b>	<b>\$89.7</b>	<b>\$95.0</b>	<b>\$90.6</b>	<b>\$96.6</b>	<b>\$102.8</b>	<b>\$109.6</b>	<b>\$116.9</b>	<b>\$396.3</b>	<b>\$912.7</b>
<b>Program Offsets</b>												
Employer Payroll Tax	\$22.0	\$18.5	\$19.4	\$20.4	\$21.4	\$22.5	\$23.6	\$24.8	\$26.0	\$27.3	\$101.7	\$226.0
Other Programs	\$1.1	\$2.4	\$3.2	\$3.4	\$3.6	\$3.9	\$4.1	\$4.4	\$4.7	\$5.0	\$13.7	\$35.8
Tax Revenues from Wage Adjustments	\$1.6	\$2.7	\$4.4	\$5.6	\$5.9	\$6.1	\$6.3	\$6.5	\$6.7	\$6.8	\$20.1	\$52.5
<b>Total Offsets</b>	<b>\$24.7</b>	<b>\$23.6</b>	<b>\$27.0</b>	<b>\$29.4</b>	<b>\$30.9</b>	<b>\$32.5</b>	<b>\$34.0</b>	<b>\$35.7</b>	<b>\$37.4</b>	<b>\$39.1</b>	<b>\$135.5</b>	<b>\$314.3</b>

Source: The Lewin Group estimates.

Figure 14  
 Net Impact of the Obama Plan on Federal Health Spending: 2010-2019  
 (billions) (continued)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
<b>Offsets To Federal Programs due to Cost Control Initiatives</b>												
Drug Re-importation Program	\$0.7	\$0.7	\$0.8	\$0.9	\$1.0	\$1.1	\$1.2	\$1.2	\$1.3	\$1.4	\$4.1	\$10.3
Medicare Price Negotiations	\$1.1	\$1.3	\$1.2	\$1.5	\$1.6	\$1.8	\$2.1	\$2.3	\$2.5	\$2.6	\$6.7	\$18.0
Eliminate Medicare overpayments	\$13.0	\$13.3	\$10.8	\$10.8	\$11.5	\$12.5	\$12.9	\$14.8	\$16.8	\$18.9	\$59.4	\$135.3
Comparative Effectiveness Research	-\$0.7	-\$0.4	-\$0.2	\$0.2	\$0.6	\$1.1	\$1.7	\$2.4	\$3.1	\$4.0	-\$0.5	\$11.8
HIT Savings	\$2.2	\$4.1	\$6.8	\$10.4	\$10.1	\$8.8	\$7.1	\$5.2	\$2.8	\$0.0	\$33.6	\$57.5
Disease Management	--	\$1.2	\$2.6	\$3.6	\$3.9	\$4.2	\$4.5	\$4.9	\$5.3	\$5.8	\$11.3	\$36.0
Care Coordination (Medical Home)	\$0.2	\$1.4	\$4.0	\$9.5	\$10.4	\$11.3	\$12.7	\$14.3	\$15.6	\$16.9	\$25.5	\$96.3
Pay-for-performance	\$2.3	\$2.6	\$2.8	\$3.1	\$3.6	\$4.1	\$4.6	\$5.2	\$5.8	\$6.8	\$14.4	\$40.9
Part-B & D premium offsets	-\$3.29	-\$4.24	-\$5.04	-\$7.00	-\$7.47	-\$7.86	-\$8.19	-\$8.80	-\$9.31	-\$9.87	-\$27.0	-\$71.1
<b>Total Federal Savings</b>	<b>\$15.51</b>	<b>\$19.97</b>	<b>\$23.76</b>	<b>\$33.00</b>	<b>\$35.23</b>	<b>\$37.04</b>	<b>\$38.61</b>	<b>\$41.50</b>	<b>\$43.89</b>	<b>\$46.53</b>	<b>\$127.5</b>	<b>\$335.0</b>
<b>Net Federal Spending</b>												
Total New Program Spending	\$82.3	\$134.8	\$165.9	\$176.1	\$187.1	\$188.8	\$201.4	\$214.5	\$228.8	\$244.0	\$696.2	\$1,823.6
<b>Net Federal Cost<sup>b/</sup></b>	<b>\$32.1</b>	<b>\$81.3</b>	<b>\$105.1</b>	<b>\$103.7</b>	<b>\$111.0</b>	<b>\$119.3</b>	<b>\$128.8</b>	<b>\$137.3</b>	<b>\$147.5</b>	<b>\$158.3</b>	<b>\$433.2</b>	<b>\$1,174.3</b>

a/ Includes administration.

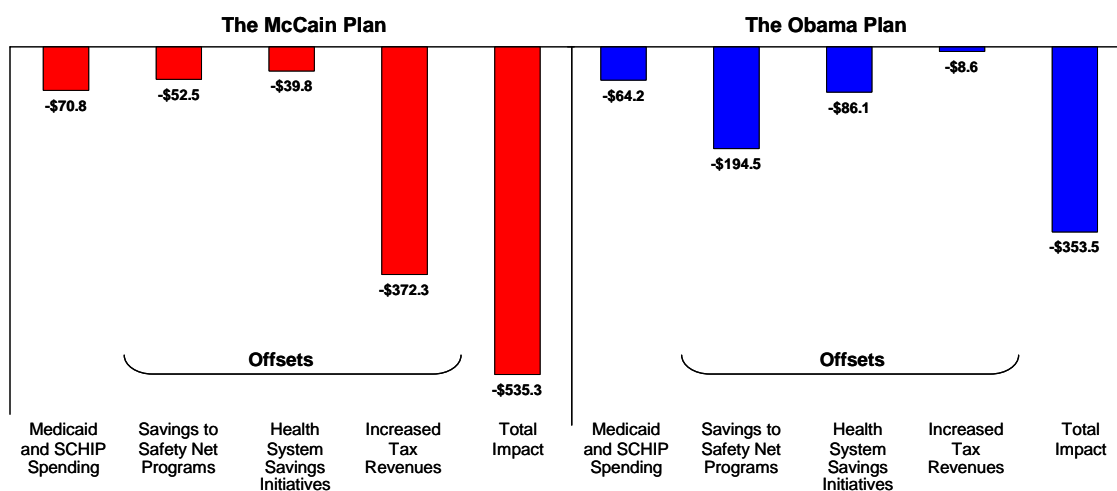
b/ Net of federal funding for HIT.

Source: The Lewin Group estimates.

## F. State Government Spending and Revenues

Both of the candidates' plans would result in net savings to state and local governments. State and local government spending would be reduced by about \$535.3 billion over the 2010 through 2019 period under the McCain proposal, primarily due to reduced spending on Medicaid and indigent care programs and increased tax revenues from the taxation of employer health benefits (*Figure 15*). State and local government spending would be reduced by about \$353.5 billion under the Obama plan, also resulting from reductions in spending for Medicaid and indigent care.

**Figure 15**  
Summary Comparison of Candidates' Plans on State and Local Governments Spending: 2010-2019<sup>a</sup>  
(billions)



a/ Increased tax revenues are counted as program offsets.

Source: The Lewin Group estimates.

There would be a net reduction in state spending for Medicaid under the McCain plan of \$70.8 billion attributed to the newly created option for states to use Medicaid funds to cover people under private health insurance with the help of the federally funded tax credits. Paying the first \$2,500 or \$5,000 of the premium with the federal tax credit reduces the amount of Medicaid funding required for the remainder of the premium, thus reducing Medicaid costs for states. State and local government costs for safety-net programs such as public hospitals and clinics would fall by about \$52.5 billion, as much of their free care becomes reimbursed by insurance for newly insured people.

State and local government tax revenues would increase by about \$372.3 billion under the McCain plan, which we count here as an offset to state health spending. Because 85 percent of states base their income taxes on federal adjusted gross income (AGI), state income taxes will increase automatically as people are required to pay income tax on the value of their health benefits. The state share of savings from the system savings features of the plan would be \$39.8 billion over the 2010 through 2019 period.

Under the Obama proposal, state spending for the Medicaid program would fall by about \$64.2 billion as the number of firms offering insurance increases. There would be an additional \$194.5 billion in savings to state and local safety-net programs due to the expansion of coverage, much of which is concentrated among lower-income people who now rely on these programs. There would also be a small increase in state income tax revenues resulting from increased wage growth as costs for insuring employers are reduced by the Obama tax credits and reinsurance programs.

A detailed summary of state and local government impacts is presented in *Figures 16* and *17*.

Figure 16  
Net Impact of McCain Plan on State and Local Government Health Spending: 2010-2019  
(billions)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
<b>Program Costs</b>												
Medicaid and SCHIP Programs	\$0.4	\$0.8	\$1.0	\$1.1	\$1.2	\$1.2	\$1.3	\$1.4	\$1.5	\$1.6	\$4.4	\$11.5
Medicaid Opt-out To Private Insurance	-\$1.3	-\$5.8	-\$9.8	-\$9.7	-\$9.6	-\$9.4	-\$9.4	-\$9.3	-\$9.0	-\$8.9	-\$36.3	-\$82.3
<b>Total Program Costs</b>	<b>-\$1.0</b>	<b>-\$5.0</b>	<b>-\$8.8</b>	<b>-\$8.6</b>	<b>-\$8.5</b>	<b>-\$8.2</b>	<b>-\$8.0</b>	<b>-\$7.9</b>	<b>-\$7.5</b>	<b>-\$7.3</b>	<b>-\$31.9</b>	<b>-\$70.8</b>
<b>Offsets</b>												
Savings to Current Safety Net Programs	\$1.6	\$3.5	\$4.7	\$5.0	\$5.3	\$5.7	\$6.0	\$6.5	\$6.9	\$7.4	\$20.1	\$52.5
Revenue From Taxing ESI Benefits	\$10.0	\$21.3	\$28.4	\$30.3	\$32.4	\$34.5	\$36.9	\$39.4	\$42.0	\$44.9	\$122.5	\$320.2
Healthcare System Savings Initiatives	\$2.3	\$2.6	\$3.0	\$3.5	\$3.7	\$4.2	\$4.5	\$5.0	\$5.3	\$5.9	\$15.0	\$39.8
Tax Revenue from Wage Increase	\$2.0	\$3.5	\$4.5	\$4.8	\$5.2	\$5.6	\$6.0	\$6.4	\$6.9	\$7.4	\$19.9	\$52.1
<b>Total Offset</b>	<b>\$15.9</b>	<b>\$30.9</b>	<b>\$40.5</b>	<b>\$43.6</b>	<b>\$46.6</b>	<b>\$49.9</b>	<b>\$53.4</b>	<b>\$57.2</b>	<b>\$61.1</b>	<b>\$65.5</b>	<b>\$177.5</b>	<b>\$464.5</b>
<b>Net Cost to States</b>												
Total Program Spending	-\$1.0	-\$5.0	-\$8.8	-\$8.6	-\$8.5	-\$8.2	-\$8.0	-\$7.9	-\$7.5	-\$7.3	-\$31.9	-\$70.8
<b>Total Net of Offsets</b>	<b>-\$16.9</b>	<b>-\$35.9</b>	<b>-\$49.3</b>	<b>-\$52.3</b>	<b>-\$55.0</b>	<b>-\$58.1</b>	<b>-\$61.4</b>	<b>-\$65.0</b>	<b>-\$68.6</b>	<b>-\$72.8</b>	<b>-\$209.4</b>	<b>-\$535.3</b>

Figure 17  
Change in Health Spending for State and Local Governments under the Obama Proposal: 2010-2019  
(billions)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
<b>Program Costs</b>												
Medicaid Program	-\$3.6	-\$5.2	-\$6.2	-\$6.6	-\$7.0	-\$7.5	-\$8.0	-\$8.5	-\$9.0	-\$9.6	-\$21.5	-\$64.2
<b>Offsets</b>												
Safety-net Programs	\$6.0	\$12.8	\$17.1	\$18.3	\$19.6	\$21.0	\$22.4	\$24.0	\$25.7	\$27.5	\$73.9	\$194.5
State and Local Worker Health Benefits	\$1.6	\$3.5	\$4.4	\$4.7	\$5.0	\$5.3	\$5.7	\$6.1	\$6.5	\$6.9	\$19.2	\$49.5
Savings from Cost Control Initiatives	\$1.1	\$2.2	\$3.7	\$5.7	\$5.7	\$5.2	\$4.5	\$3.8	\$2.9	\$1.8	\$18.4	\$36.6
Tax Revenues from Wage Adjustments	\$0.3	\$0.6	\$0.8	\$0.8	\$0.9	\$0.9	\$1.0	\$1.1	\$1.1	\$1.2	\$3.3	\$8.6
Total Offsets	\$9.0	\$19.1	\$26.0	\$29.5	-\$31.2	\$32.4	\$33.6	\$34.9	\$36.2	\$37.4	\$114.8	\$289.3
<b>Net Cost to States</b>												
Total Program Spending	-\$3.6	-\$5.2	-\$6.2	-\$6.6	\$0.0	-\$7.5	-\$8.0	-\$8.5	-\$9.0	-\$9.6	-\$21.5	-\$64.2
Total Net of Offsets	-\$12.6	-\$24.3	-\$32.1	-\$36.1	-\$38.2	-\$39.9	-\$41.6	-\$43.4	-\$45.2	-\$47.0	-\$136.3	-\$353.5



## G. Employer Impacts

As discussed above, both candidates' proposals would alter financial incentives for employers resulting in changes in the number of employers providing health insurance to their workers. We estimate a net reduction in the number of workers and dependents with ESI of 9.4 million people under the McCain plan. Under the Obama plan, the number of people with ESI would increase by about 4.7 million (*Figure 18*). In this section, we discuss the impact of these proposals on private employer coverage and costs.

### 1. Changes in Employer Coverage

Under the McCain plan, about 16.1 million workers and dependents would lose ESI. Our analysis indicates that this would occur primarily among firms where workers are now able to obtain coverage in the non-group market for less than it would cost under their employer's plan. This reflects the availability of the tax credit for non-group insurance, the subsidized high-risk pools for people with chronic illness and changes in insurance markets that increase premiums for firms with older and relatively less healthy groups.

This loss of coverage under the McCain plan would be partly offset by increased participation in the plans that remain. About 4.7 million workers and dependents who have declined the coverage available to them at work would now take that coverage with the aid of the new tax credit. Another 2.0 million people would become covered under new employer plans. These include firms with younger and healthier workers who would be able to obtain insurance at a lower cost as a result of allowing cross-state purchases of health insurance.

The Obama plan requires medium and large employers to either offer insurance or pay a payroll tax, which we assume would be equal to 6.0 percent of employee wages and salaries. (We assume that this requirement pertains to firms with 25 or more workers.) It also offers small employers the option of purchasing lower-cost coverage in the National Plan. We estimate that about 22.5 million workers and dependents are in a firm that would discontinue private coverage, given the financial incentives under the proposal.

However, of these, about 12.9 million people would be in small firms (under 25 workers) where the employer will now purchase coverage for their workers in the National Plan which, as discussed below, would typically have lower premiums than comparable private health plans. The other 9.6 million people would be in lower-wage firms where many of the workers now become eligible for publicly subsidized coverage under Medicaid or the new premium subsidy program.

**Exhibit 3**  
**Impact of the Small Employer Tax Credit under the Obama Plan**

The Obama plan would provide a tax credit for up to 50 percent of the employer cost of insurance for small employers. The campaign has not provided information on the eligibility requirements for the credit and the formula used to determine the tax credit amounts. However, the campaign has indicated that they intend to ask the Department of the Treasury to define the details of the tax credit such that the federal cost of the program does not exceed \$6.0 billion.

To keep the cost of the credit to the \$6.0 billion budgeted amount, we had to limit the credit to only employers with 10 or fewer workers. We also found that we had to limit the credit to only firms with an average payroll of less than twice the minimum wage.

Using these eligibility criteria, there are about 3.6 million workers and dependents in small firms that would take the tax credit. Of these, about 1.9 million are in eligible small firms that are already offering insurance. The credit would also go to employers of 1.7 million workers and dependents in firms where the tax credit induces employers to offer coverage. Total tax credit payments would be about \$6.0 billion, of which \$3.9 billion (65 percent) would be for firms that already provide insurance, and \$2.1 billion would be for currently non-insuring firms that start to offer coverage.

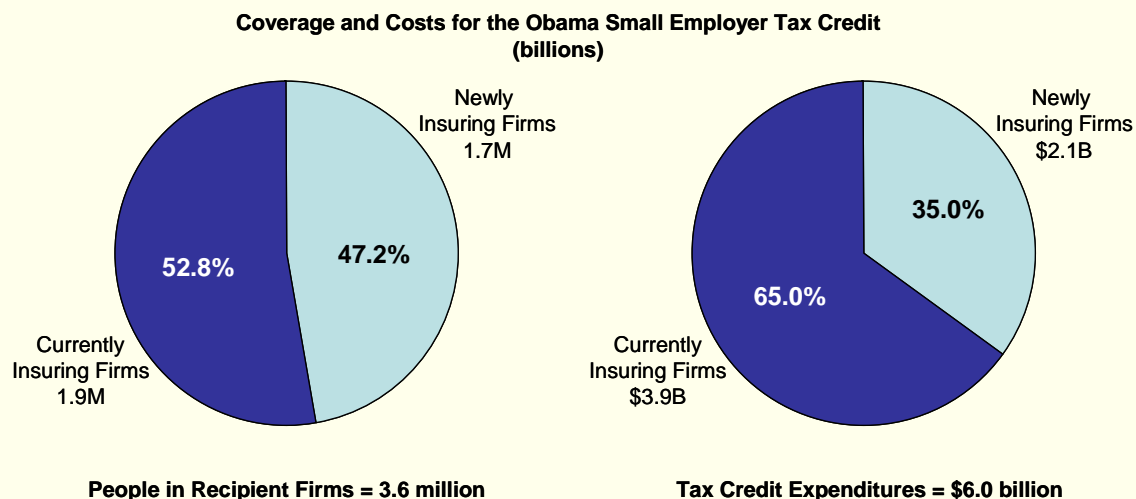
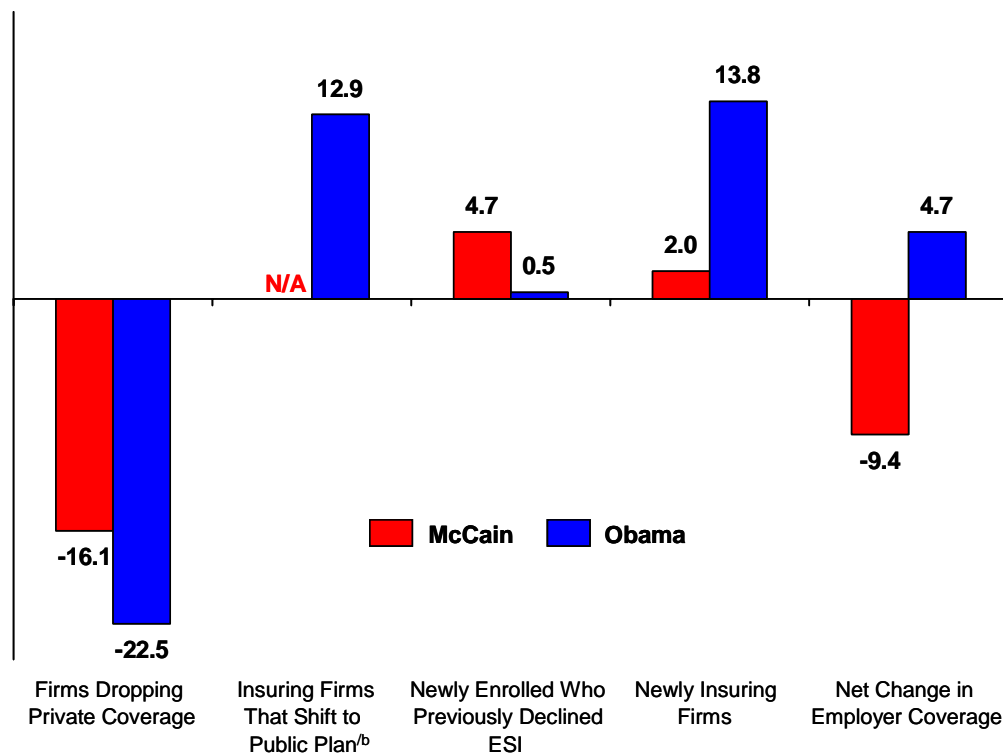


Figure 18  
Changes in Employer Coverage Under Candidates' Plans: 2010<sup>a/</sup>  
(millions)



a/ Assumes both plans are fully implemented in 2010.

b/ Includes currently insuring firms who purchase coverage for their workers in the National Plan.

Source: The Lewin Group estimates.

About 13.8 million workers are in firms that would decide to start sponsoring coverage under the Obama plan, of which, 5.6 million would be in firms purchasing coverage through the national public plan and 8.2 million would be in firms that start to purchase private coverage. These include firms where the cost of paying the payroll tax is greater than the cost of purchasing coverage. It also reflects an overall reduction in premiums due to the small employer tax credit and the reinsurance program. The limitations on health status rating under the Obama plan are also likely to cause some firms to start offering coverage.

Few of those who have declined employer coverage under current law would take employer coverage under the Obama plan. This is because the premium subsidies are not available to people with access to employer coverage.

## 2. Employer Spending for Health

Total spending for private employer health insurance under current law will be about \$450.1 billion in 2010 (*Figure 19*). This includes the value of the employer share of the cost of health

insurance among private employers.<sup>21</sup> Under the McCain plan employer spending in 2010 would decline by about \$40.2 billion primarily due to terminations of employer health coverage.

**Figure 19**  
Changes in Private Employer Health Spending under Candidates' Plans: 2010 (billions)<sup>a/</sup>

	The McCain Plan	The Obama Plan
Current Law Spending for Health <sup>b/</sup>	\$450.1	\$450.1
<b>Changes in Spending Under Proposals</b>		
Change in the Number of Firms Providing Coverage	-\$37.5	\$23.9
Costs for Previously Declined Coverage	\$12.1	\$0.1
Payroll Tax for Non-insuring Firms	N/A	\$16.2
Savings from Reduced Mandated Benefits	-\$3.9	N/A
Savings from Reduced Cost Shift	-\$1.6	-\$2.3
System Savings Initiatives	-\$9.3	-\$5.0
Small Business Tax Credits	N/A	-\$6.0
Employer Reinsurance	N/A	-\$24.9
<b>Net Impact on Employers</b>	<b>-\$40.2</b>	<b>\$2.0</b>

a/ Includes spending by private employers for health insurance.

b/ Excludes employee contributions.

Source: The Lewin Group estimates.

Private employer health spending under the Obama plan would increase by about \$2.0 billion in 2010. Thus, increased employer spending from the payroll tax and increased coverage are roughly offset by the employer reinsurance program and other savings.

Employer health spending in 2010 would decline by an average of about \$356 per worker under the McCain plan (*Figure 20*). Spending per worker would increase by \$15 per worker in the Obama plan. Both plans would tend to reduce employer health spending per worker in currently insuring firms. *Figure 21* summarizes the impact of these proposals on private employers by firm size.

### 3. People who Lose Employer Coverage

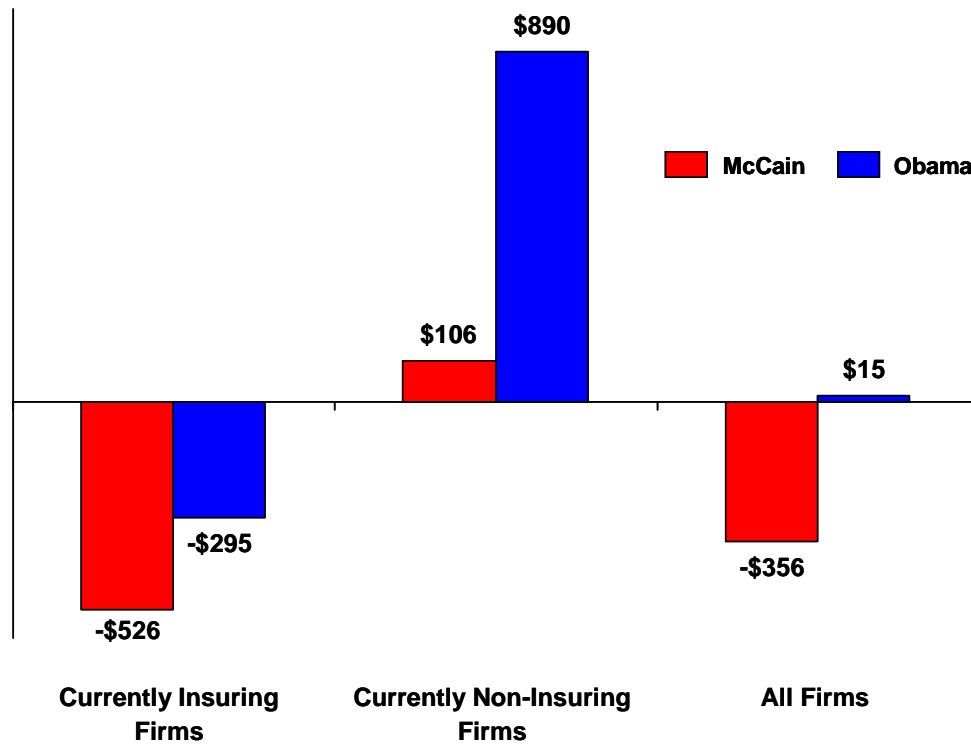
Not all of those who would lose ESI coverage under the McCain proposal would obtain coverage elsewhere. Of the 16.1 million people in firms that discontinue coverage, about half would obtain coverage in the non-group market, 15.6 percent would obtain coverage in the high-risk pool and 7.4 percent would become covered under Medicaid. Under the McCain plan, about 26.7 percent (4.3 million) would become uninsured (*Figure 22*).

Under the Obama plan, about 57.3 percent of workers in firms that discontinue private insurance would buy coverage under the new National Plan. About 25.3 percent (5.7 million)

<sup>21</sup> The impact on health benefits costs for government employees is incorporated into our public spending estimates presented above.

would become covered under Medicaid and 10.7 percent would take non-group coverage. About 6.7 percent (1.5 million) would become uninsured.

Figure 20  
Change in Private Employer Health Spending per Worker under Candidates' Plan by Current Insuring Status: 2010 <sup>a/</sup>



a/ Includes spending by private employers for health insurance. Excludes employee contributions.  
Source: The Lewin Group estimates.

## H. Impacts on Consumers

In this section, we present our estimates of the impact of the candidates' proposals on health spending for families. Both proposals show dramatic reductions in health spending across most demographic and economic groups. However this is overwhelmingly explained by the fact that neither candidate has specified how they would pay for these health plans. These results effectively assume that the full amount of the net increase in federal spending under the two plans is financed entirely with government borrowing.

In particular, these results suggest that savings to families under the McCain proposal would be over twice as large as under the Obama plan. But, this is merely a reflection of the fact that the McCain plan finances twice as much coverage subsidies with deficit spending. Therefore one can conclude little about the relative impacts of these plans until the financing methods are specified.

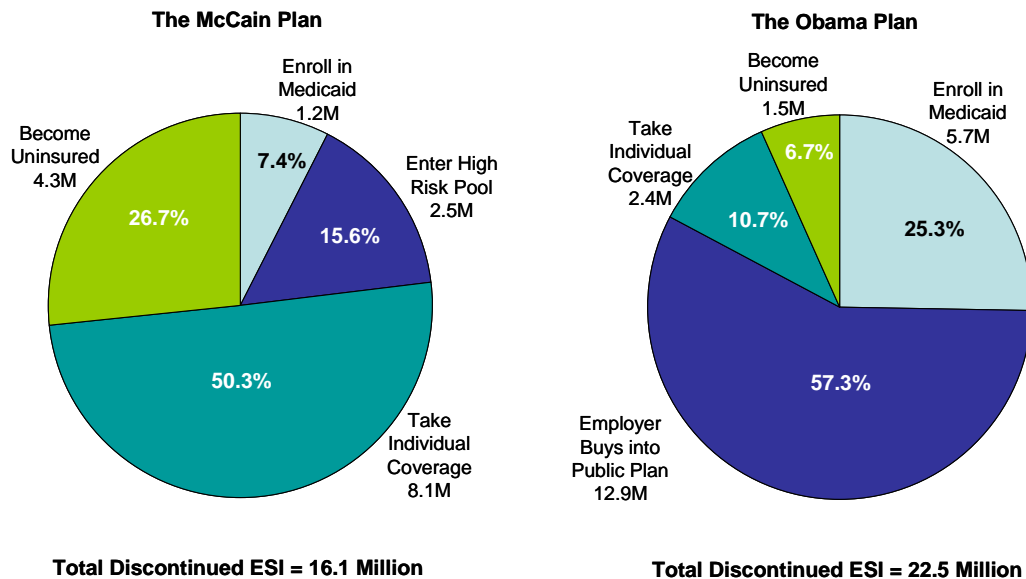
These analyses are useful only for assessing the distributional impacts of the parts of the candidates' plans that have been specified. These include the effect of the provisions related to coverage, insurance market reforms, premium subsidies and tax subsidy provisions of these plans. If the funding methods were to be identified, these distributional impacts would be dramatically different.

**Figure 21**  
Annual Change in Private Employer Spending Per Worker

	The McCain Plan			The Obama Plan		
	Insuring Firms	Non-Insuring Firms	All Firms	Insuring Firms	Non-Insuring Firms	All Firms
<b>Firm Size - Number of Workers in the Firm</b>						
Under 10	-\$1,507	\$96	-\$642	-\$931	\$659	-\$72
10-24	-\$714	\$100	-\$347	-\$361	\$786	\$157
25-99	-\$254	\$106	-\$153	-\$116	\$1,193	\$252
100-499	-\$432	\$94	-\$340	\$6	\$968	\$176
500-999	-\$1,106	\$16	-\$930	-\$759	\$1,500	-\$405
1,000-4,999	-\$340	\$169	-\$194	-\$237	\$1,053	\$133
5,000 or more	-\$240	\$0	-\$240	-\$239	\$0	-\$239
<b>Industry</b>						
Construction	-\$589	\$118	-\$328	-\$252	\$1,088	\$243
Manufacturing	-\$656	\$53	-\$560	-\$573	\$851	-\$380
Transportation	-\$700	\$106	-\$531	\$131	\$1,221	\$359
Wholesale Trade	-\$240	\$51	-\$193	-\$206	\$1,553	\$76
Retail Trade	-\$404	\$213	-\$225	-\$265	\$688	\$11
Services	-\$471	\$94	-\$299	-\$241	\$938	\$117
Finance	-\$635	\$58	-\$520	-\$388	\$329	-\$269
Other	-\$531	\$39	-\$334	-\$368	\$679	-\$7
<b>Total</b>						
<b>Total</b>	<b>-\$521</b>	<b>\$106</b>	<b>-\$356</b>	<b>-\$298</b>	<b>\$890</b>	<b>\$15</b>

Source: The Lewin Group estimates.

**Figure 22**  
**Workers and Dependents in Firms that Discontinue Employer Health Insurance under**  
**Candidates' Plans: 2010<sup>a/</sup>**  
**(millions)**



a/ Assumes programs are fully implemented in 2010.  
 Source: The Lewin Group estimates.

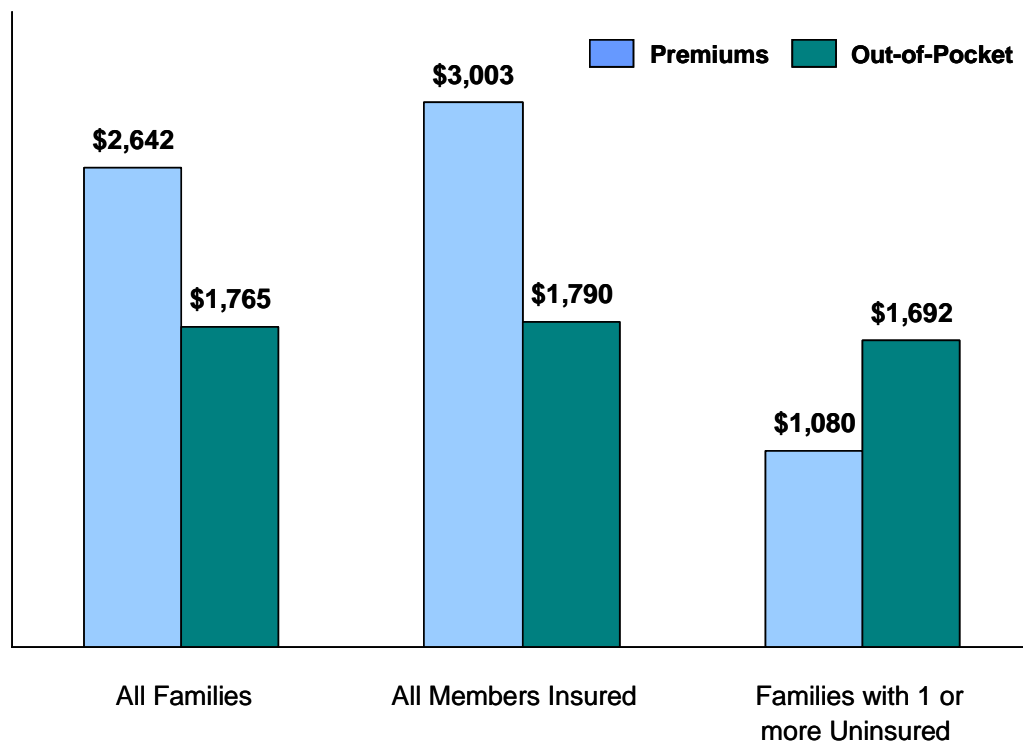
### 1. Current Family Spending for Health

We estimate that family spending for health care will be \$4,407 per family in 2010 under current law (*Figure 23*). This includes direct payments for care of \$1,765, which includes co-payments, deductibles and purchases of services not covered by a health plan. It also includes premium payments averaging about \$2,642 per family. This includes the employee share of the premium for ESI, premiums for non-group coverage and the Medicare Part B premium for Medicare covered people.

Total family spending for health is on average \$2,772 per family with one or more uninsured family member. This compares with an average of \$4,793 for families where all members are insured.

Under current law, average annual family out-of-pocket spending for health services and premiums increases from an average of about \$1,887 for families headed by someone under age 25 to an average of \$6,061 for families headed by someone age 55 to 64 (*Figure 24*). Out-of-pocket spending also varies from about \$1,270 for families with incomes below \$10,000 to \$7,400 for families with incomes of \$150,000 or more.

Figure 23  
Average Family Health Spending under Current Law in 2010



Source: The Lewin Group estimates.

## 2. Changes in Average Annual Family Health Spending Under Proposals

Both of the candidates' plans would affect out-of-pocket spending for health care. For purposes of this analysis, we define the change in family spending for health care to include the following:

- Changes in premiums for coverage net of any premium subsidies received under these proposals;
- The net change in tax subsidies resulting from limits on the income tax exclusion for employer benefits and newly created tax credits;
- Changes in out-of-pocket payments for health services including deductibles, co-payments and payments for uncovered services;
- Changes in wages resulting from the proposal's impact on employer health costs. This is based on economic theory and research showing that changes in employer health spending have historically been passed back to workers in the form of changes in wage growth. Increases in wages are counted as an offset to family health spending; and
- Changes in family tax payments to fund these programs (none specified for the candidates' proposals).

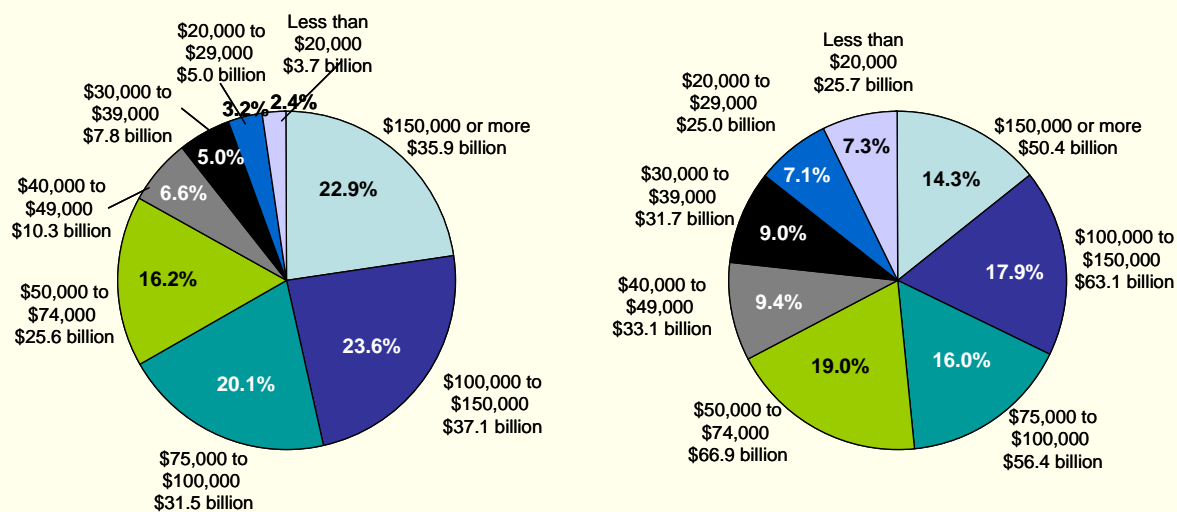


#### Exhibit 4 Changes in Tax Benefits for Families by Family Income Level

The current law tax exclusion for employer provided health benefits will reach \$157.0 billion in 2010. This is the total amount of personal income tax revenues forgone by providing this exemption, including the value of the employer premium contribution and the value of the worker contribution in firms with section 125 plans. The revenues foregone by excluding health benefits in computing Social Security and Medicare payroll taxes, which is retained under the McCain plan, will be \$87.2 billion in 2010. Under the McCain proposal this is replaced with a tax credit for private insurance that would cost \$352.3 billion if fully implemented in 2010. This is a net increase in tax benefits for health insurance coverage of \$195.3 billion (\$352.3 billion less \$157.0 billion).

The tax credit would have the effect of shifting a greater share of the tax benefits for health insurance from higher income groups to lower- and middle-income groups. Under the McCain plan, about 7.3 percent of the tax credit would go towards coverage for families with incomes of less than \$20,000, compared with only 2.4 percent under the current income tax exclusion. While about 46.5 percent of the current income tax exclusion goes to families with incomes over \$100,000 while 32.2 percent of the tax credit goes to families in this income group.

**Distribution of the Current Federal Income Tax Expenditure and the McCain Federal Tax Credit Compared: 2010 <sup>a/</sup>**  
(billions)



**Current Law Federal Income Tax Exclusion = \$157.0 billion**

**Total McCain Tax Credit = \$352.3 billion**

a/ Assumes the program is fully implemented in 2010

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

The number of families receiving tax benefits for health insurance would increase by 28.4 million families under the McCain proposal. Most of the increase is for people purchasing non-group coverage and people in low-income groups who would benefit from the refundable tax credit.

The McCain plan would increase family premium payments by an average of \$379 per family. Direct payments for health services also would increase by about \$105 per family. This would be more than offset by a net increase in tax subsidies of \$1,570 which we count as an offset to family health spending. Wage gains resulting from savings to employers, including those who discontinue coverage, would average \$324 per family and are also counted here as an offset to family health spending.

The Obama plan would reduce average annual net family health spending by an average of about \$426 per family. Average family premium payments would decline by about \$185, and average direct payments for health services would decline by about \$253. Wages would on average change little, because on average, increases in employer spending under the plan are offset by savings from the small employer tax credit, reinsurance and system savings initiatives.

*Figure 24* illustrates how increased employer costs in firms that do not currently offer insurance would be passed back to workers in the form of reduced wage growth. Under the Obama plan, for example, families with incomes below \$10,000 will on average see a wage loss of \$103 per family due to an increase in their employer's cost. This wage loss is counted here as an increase in family health spending. In fact, families with incomes below \$50,000 would on average see some wage loss due to the increase in employer costs under the proposal.

### *3. Impacts by Income and Age*

*Figure 25* shows the change in average family health spending, including wage effects, under these plans by family income. Both plans would reduce family health spending at all income levels. The McCain plan would reduce spending for families with income under \$10,000 by an average of \$507 per family, with savings increasing with income. Savings would be \$1,915 per family with incomes over \$150,000.

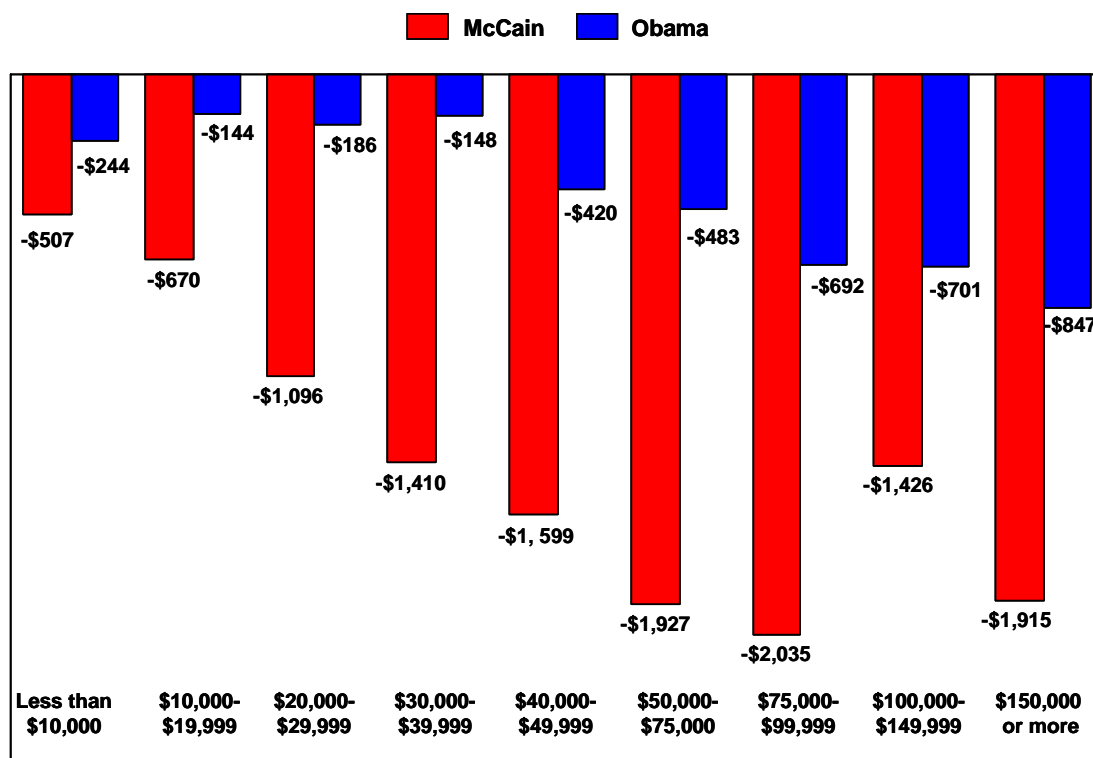
Savings under the Obama plan would also increase as income rises. Savings would range between \$244 per family with less than \$10,000 in annual income to \$847 per family with incomes over \$150,000. Under the Obama plan, this is partly a reflection of the fact that higher income people are older and tend to benefit from guaranteed issue and the elimination of health status rating.

*Figure 26* shows the average change in family health spending by age of family head. Both proposals show savings in average family spending in each age group. As discussed below, these impacts would change dramatically when the methods of financing are identified.

**Figure 24**  
**Detailed Changes in Annual Family Health Spending under Candidates' Plans by Family Characteristic: 2010 - 2019**

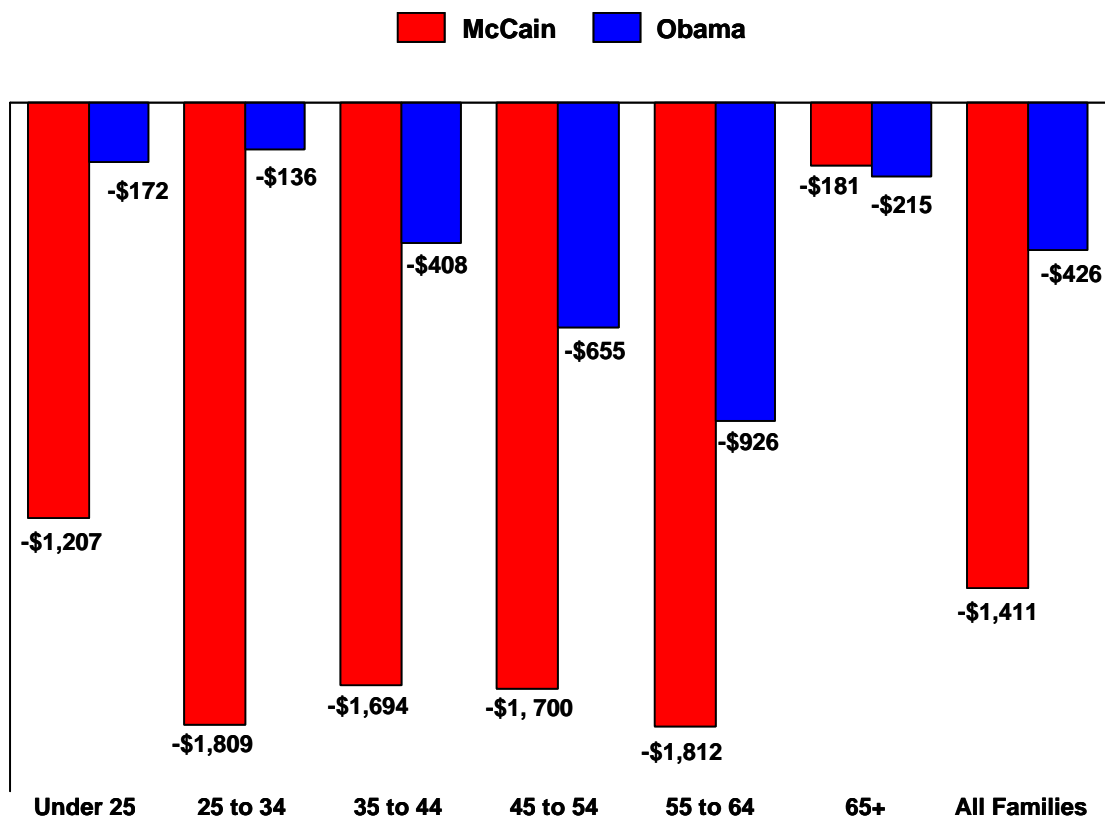
		The McCain Proposal					The Obama Proposal			
	Average Family Health Spending Under Current Law	Change in Premium Payments	Change in Out-Of-Pocket Payments	Increase in Tax Benefits (counted as an offset)	Wage Gains (counted as an offset)	Net Impact	Change in Premium Payments	Change in Out-Of-Pocket Payments	Wage Change (counted as an offset)	Net Impact
<b>Family Income</b>										
Less than \$10,000	\$1,270	\$124	-\$39	-\$585	-\$6	-\$507	-\$64	-\$283	\$103	-\$244
\$10,000 - \$19,999	\$2,158	\$244	-\$61	-\$849	-\$5	-\$670	-\$49	-\$252	\$157	-\$144
\$20,000 - \$29,999	\$3,140	\$364	-\$43	-\$1,328	-\$89	-\$1,096	-\$67	-\$247	\$128	-\$186
\$30,000 - \$39,999	\$3,745	\$495	\$0	-\$1,718	-\$187	-\$1,410	-\$69	-\$161	\$82	-\$148
\$40,000 - \$49,999	\$4,574	\$519	\$31	-\$1,899	-\$250	-\$1,599	-\$164	-\$306	\$50	-\$420
\$50,000 - \$74,999	\$5,016	\$432	\$72	-\$2,026	-\$404	-\$1,927	-\$250	-\$166	-\$67	-\$483
\$75,000 - \$99,999	\$6,060	\$414	\$89	-\$1,892	-\$646	-\$2,035	-\$362	-\$211	-\$119	-\$692
\$100,000 - \$149,999	\$6,427	\$447	\$684	-\$1,919	-\$639	-\$1,426	-\$280	-\$282	-\$139	-\$701
\$150,000 or more	\$7,400	\$369	\$206	-\$1,793	-\$697	-\$1,915	-\$348	-\$450	-\$49	-\$847
<b>Age of Family Head</b>										
Under 25	\$1,887	\$286	-\$35	-\$1,302	-\$157	-\$1,207	-\$31	-\$212	\$71	-\$172
25 - 34	\$3,044	\$594	\$22	-\$2,061	-\$364	-\$1,809	-\$106	-\$109	\$79	-\$136
35 - 44	\$4,152	\$550	\$72	-\$1,894	-\$422	-\$1,694	-\$131	-\$317	\$40	-\$408
45 - 54	\$4,923	\$447	\$379	-\$2,046	-\$480	-\$1,700	-\$231	-\$376	-\$48	-\$655
55 - 64	\$6,061	\$266	\$133	-\$1,798	-\$413	-\$1,812	-\$470	-\$388	-\$68	-\$926
65 +	\$5,752	\$72	-\$12	-\$194	-\$46	-\$181	-\$127	-\$100	\$12	-\$215
<b>Current Out-of-pocket and Premiums</b>										
Less than \$1,000	\$243	\$658	\$19	-\$1,268	\$23	-\$568	\$374	\$36	\$216	\$626
\$1,000 - \$2,499	\$1,676	\$542	\$65	-\$1,473	-\$213	-\$1,080	\$248	-\$14	-\$174	\$60
\$2,500 - \$4,999	\$3,685	\$423	\$198	-\$1,606	-\$424	-\$1,409	\$134	-\$129	-\$248	-\$243
\$5,000 - \$9,999	\$7,201	\$275	\$338	-\$1,772	-\$636	-\$1,795	-\$641	-\$270	\$28	-\$883
\$10,000 or more	\$15,344	-\$473	-\$257	-\$1,997	-\$554	-\$3,281	-\$2,041	-\$1,603	\$338	-\$3,306
<b>Current Insured Status</b>										
All in Family Insured	\$4,785	\$69	\$178	-\$1,426	-\$442	-\$1,621	-\$345	-\$173	-\$132	-\$650
Some in Family Uninsured	\$2,772	\$1,719	-\$208	-\$2,192	\$182	-\$499	\$506	-\$596	\$637	\$547
<b>All Families</b>	<b>\$4,407</b>	<b>\$379</b>	<b>\$105</b>	<b>-\$1,570</b>	<b>-\$324</b>	<b>-\$1,411</b>	<b>-\$185</b>	<b>-\$253</b>	<b>\$12</b>	<b>-\$426</b>

Figure 25  
 Net Change in Average Health Spending by Family Income under Candidates' Plans: 2010  
 (Assumes Deficit Funding for Net Federal Costs)



a/ Assumes both programs are fully implemented in 2010.  
 Source: The Lewin Group estimates.

Figure 26  
 Net Change in Average Family Health Spending by Age of Family Head  
 under Candidates Plans: 2010  
 (Assumes Deficit Funding for Net Federal Costs)



a/ Assumes both programs are fully implemented in 2010.  
 Source: The Lewin Group estimates.

## I. Caveats

Although our analyses are based upon the best data and research of which we know, our estimates should be considered illustrative of potential impacts rather than point estimates of actual outcomes. Our estimates are largely based upon analyses of how changes in the cost of insurance affect decisions by employers and individuals to offer or take coverage. We assume that people would respond to a tax credit or deduction as though it were a reduction in insurance premiums. In fact, people may not equate these forms of subsidies with a simple price reduction and may not respond to these subsidies as expected.

We also make assumptions regarding how employers respond when tax subsidies and Medicaid coverage becomes available as a subsidized alternative to employer health benefits. Our estimates are based upon the assumption that employers would tend to drop their coverage if their workforce could obtain tax subsidized non-group or Medicaid coverage for a lower cost. However, we have no objective measures of how employers will respond. With what little is known, it is difficult to be sure of the likely impacts of changes in the relative tax advantages of employer insurance on the number of employers sponsoring coverage.

Our estimates of the impact of various changes in the health care system proposed by both candidates are speculative. These include funding for HIT, comparative effectiveness research, coordination of care for the chronically ill, pay-for-performance and disease management. In some cases, we are relying upon estimates of how these policies have affected costs when implemented in individual states or in various demonstration programs. Despite this, there remains considerable uncertainty about the potential effects of these policies.

We also do not measure other economic effects resulting from these policies. For example, the McCain plan would enable people to detach themselves from their employer for health coverage by making the tax credit available for the purchase of non-group coverage as well. This would reduce the phenomenon of job lock and could enhance new firm formation. Expanded coverage under both plans could also enhance worker productivity. We do not estimate these economic effects.

- The Obama plan imposes a mandate to cover all children but does not specify an enforcement mechanism. Our estimates of children's coverage under the plan would improve if an enforcement mechanism or automatic enrollment mechanism is specified.
- The McCain plan will allow individuals to purchase insurance coverage across state lines thereby reducing the effectiveness of regulations in the home state. Another secondary impact of allowing cross-state purchase of coverage is that it lowers the barriers to entry into the market by insurers. This could potentially negatively impact consumer protections, and affect costs by increasing under-insurance. Consumer protection regulations could be

minimized as well. We did not estimate the impact of these effects on coverage, quality or system costs.<sup>22</sup>

- Under the McCain plan, if out-of-state insurers are able to minimize the effectiveness rigorous in-state regulations resulting in migration of healthier individuals to these insurers, the continuous change in the characteristics of the in-state pool would be reflected in the change in the premium, which in turn would affect the migration of individuals in favor of out-of-state coverage.
- Under the McCain plan, dropping the ESI tax advantage and shifting the emphasis to the individual non-group market through individual tax credits also has a potential cost impact on employers offering insurance on a per covered worker basis. As the size of the insured group participating in the employer's insured plan declines, and becomes relatively more expensive, the premiums will escalate very rapidly. The resulting health care cost experience would increase premiums, reduce the size of the group, and increase administrative costs as a percent of premium. However, the migration of workers out of the plan will still represent an aggregate reduction in costs to the employer.
- We assumed no shortage of private individual insurance in modeling the effects of the candidates' proposals. That is, we assumed that commercial insurers would participate in the individual market and be able to meet demand for the policies. This is an important caveat because in many states, insurance departments have difficulty in inducing or requiring insurers to participate in the individual market, with high risk pools being one approach to mitigate the risk and induce participation.
- It is unclear whether insured individuals who are shifting to new forms of coverage (e.g., individuals covered by ESI who shift to individual non-group coverage) will retain benefit packages with similar actuarial values. In the event that coverage is less through reduced benefits (e.g., no chiropractic care), more restrictive coverage criteria, or additional benefit limitations, out-of-pocket spending may increase. We have not attempted to estimate increases in out-of-pocket expenditures due to reductions in the comprehensiveness of insurance coverage under the McCain or the Obama proposals.

The appendices to this report present a detailed description of how we addressed each of the proposals presented by the candidates. We summarize the available literature in these areas and present the results of our data analyses. We then explain the assumptions we made to model the impacts of these policies and explain how estimates were developed from these assumptions. We invite interested parties to review these materials and comment on our approach.

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<sup>22</sup> Mila Kofman, J.D. and Karen Pollitz, M.P.P., "Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change," Health Policy Institute, Georgetown University, April 2006, available at <http://www.pbs.org/now/politics/Healthinsurancereportfinalkofmanpollitz.pdf>.







# McCain and Obama Health Care Policies: Cost and Coverage Compared Appendices

October 15, 2008



# McCain and Obama Health Care Proposals: Cost and Coverage Compared Appendices

October 8, 2008  
(Revised October 15, 2008)









## Appendix A: Analysis of Senator McCain's Health Proposals by Major Provision

Senator McCain provides a broad outline of a health reform proposal that would potentially reshape health care coverage for tens of millions of Americans, while covering many of the uninsured. The centerpiece of the plan is a new refundable tax credit that would be available to all Americans with private insurance, except those covered under Medicare or the TRICARE program covering military dependents and retirees.

The credit amount would be \$2,500 for single coverage and \$5,000 for family coverage and would be available to both those who have employer coverage and those who purchase non-group coverage on their own. The credit replaces the current income tax exclusion for employer provided benefits. This means that people with employer health insurance would be required to add the cost of the coverage to their earnings and pay income taxes on it (employers would continue to be able to deduct health benefits as a cost of doing business). However, the employer health benefits exclusion is retained for the Social Security and Medicare payroll taxes. As discussed below, most people will find that the tax credit amount is greater than the amount of additional tax they would pay by eliminating the tax exclusion.

Under the McCain plan, Medicaid beneficiaries would have the option to opt out of the Medicaid program and take private coverage using a tax credit and a cash-out payment amount that is based on the actuarial cost of their coverage under Medicaid.

The McCain plan also permits employers and individuals to purchase coverage across state lines. This would enable employers and consumers to escape much of the cost of mandated health benefits. It would also enable employers in states with restrictive rate compression, financial integrity, and consumer protection laws to obtain coverage at a lower rate from carriers in less regulated states, particularly in cases where they have relatively younger and healthier workers. The plan also includes a program that would effectively expand the availability of high risk pools for those who are unable to obtain insurance due to health status.

Finally, the McCain proposal includes several proposals designed to help reduce the growth in health care costs. We discuss the plan and the methods used to simulate the program in the following sections:

- Reshaping Health Coverage with a Tax Credit;
- Permit the Sale of Coverage Across State Lines;
- Establish the Guaranteed Access Plan (GAP);
- Simulation of Coverage and Costs;
- Medicaid Opt-out Provisions;
- Chronic Care Initiatives; and
- Health Information Technology.

## A. Reshaping Health Coverage with a Tax Credit

The tax credit proposal is designed to expand health insurance coverage, correct inequities in the current tax code, and create incentives to be more cost conscious when selecting a health plan. We explain how the plan addresses these issues in the following sections:

- Expand private insurance coverage;
- Correct inequities in the tax code;
- Create incentives to control costs; and
- Breaking the constraints of employer-sponsored coverage.

### 1. *Expand Private Insurance Coverage*

The program provides a refundable tax credit for people purchasing private insurance. The credit is equal to \$2,500 for single individuals and \$5,000 for families. The credit is refundable, which means that the amount of the tax credit can exceed the amount of taxes owed. Thus, people with little or no income may receive the credit, regardless of whether they are required to pay taxes.

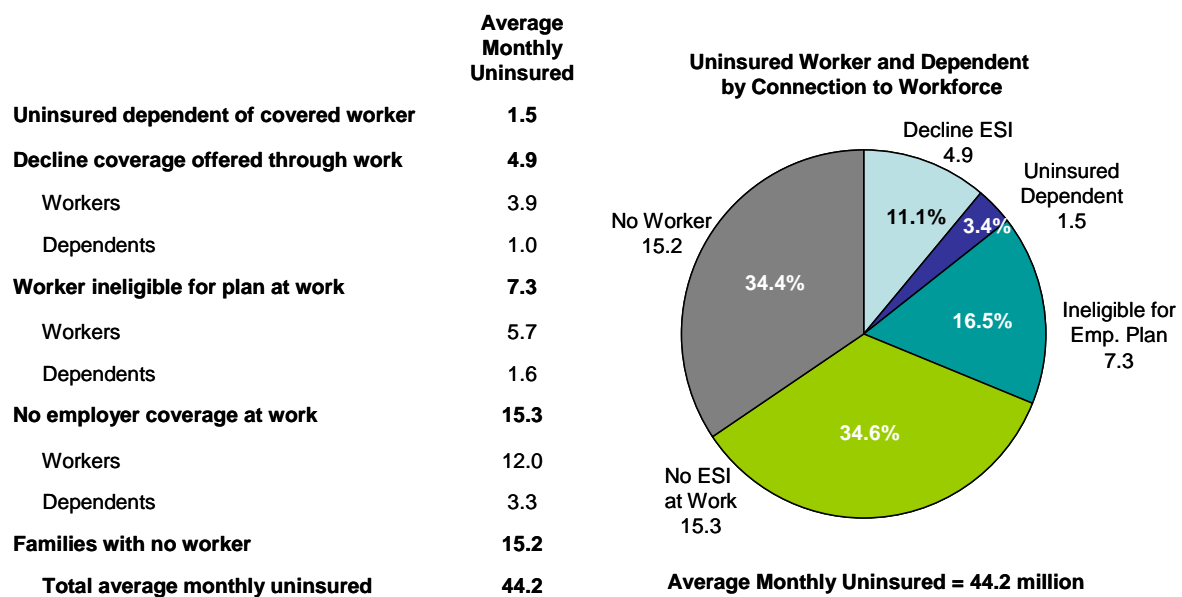
The tax credit could be used to offset the worker premium contribution requirement for coverage offered through work. This is especially important to low-wage workers in insuring firms, who have access to the coverage but are unable to afford the worker contribution. We estimate that there are about 4.0 million uninsured workers and dependents that have declined the coverage offered through work. In fact, 17 percent of the uninsured have access to coverage as a worker or dependent of a worker through an employer plan (*Figure A-1*).

People who do not have access to coverage through work would be able to use the credit to purchase private non-group coverage. People could arrange to have the credit paid directly to the insurer. Although not addressed in the description of the McCain proposal, we assume that people would be able to arrange advance payments of the credit so that the credit is available to people during the year when it is needed to make premium payments, rather than waiting until the following year when people file their taxes. Advance payments could be arranged through withholding (i.e., negative withholding), subject to reconciliation at year's end when taxes are filed.

One of the chief concerns with using the tax system to provide coverage subsidies is that the uninsured tend to have low incomes and are not required to file taxes. However, the March Current Population Survey (CPS) data indicate that about 77 percent of the uninsured either filed a tax return or were in a family that filed a tax return. Thus, most of the uninsured can be reached through the tax system (*Figure A-2*).



Figure A-1  
Average Monthly Uninsured by Connection to Workforce in 2006  
(millions)



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

Figure A-2  
Distribution of Uninsured Tax Filers by Marginal Tax Rate in 2004  
(thousands)

	With Earnings	Without Earnings	Total
<b>Uninsured Tax Filing units in US</b>			
Total Potential Filers	23,004	5,016	28,020
Non-Filers	2,848	3,330	6,178
<b>Uninsured Filers by Marginal Tax Rate</b>			
0%	5,982	648	6,630
10%	4,992	354	5,346
15%	7,389	484	7,873
27%	1,424	140	1,564
30%	242	43	285
35%	60	9	69
39%	67	7	74
<b>Total Filers</b>	<b>20,156</b>	<b>1,686</b>	<b>21,842</b>

a/ Includes tax filers with one or more uninsured family member.

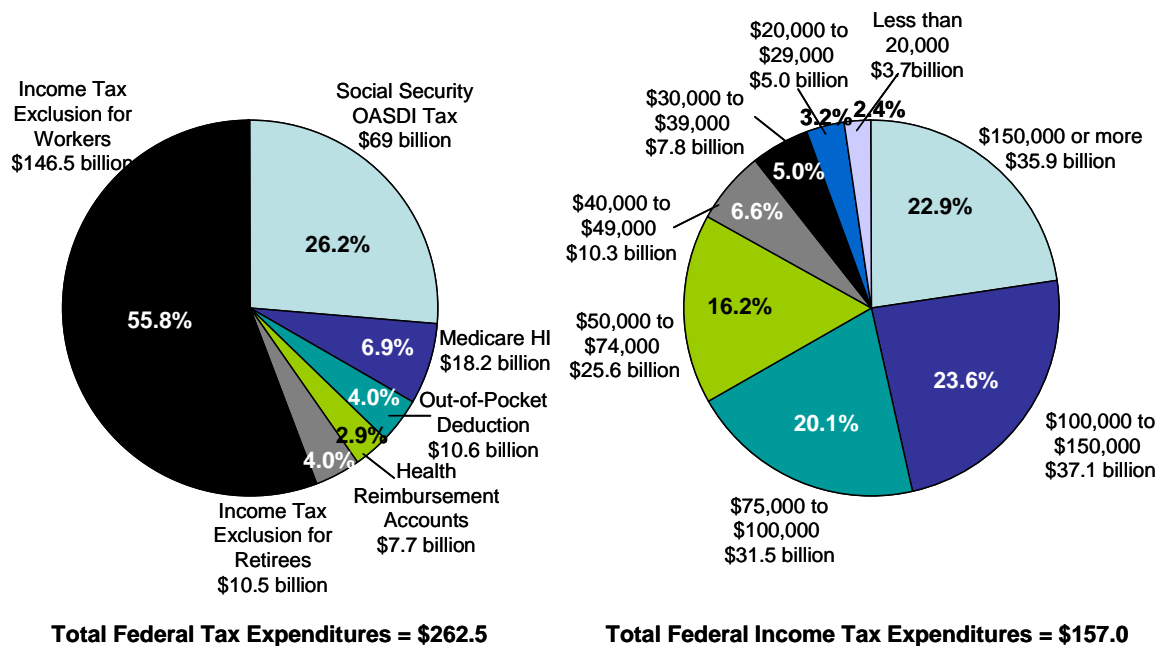
Source: The Lewin Group estimates using the 2005 Current Population Survey (CPS) Data.

## 2. Correct Inequities in the Tax Code

Under current law, the amount paid by the workers and the employer for employer-provided health coverage is not taxed as income to the beneficiary for purposes of income and payroll taxes, even though it is compensation to the worker. For example, if someone were paid with a house or a car, the IRS would require the worker to impute the value of these items and pay tax on them. However, no tax is paid on health benefits.

The total amount of tax revenues that the federal government forgoes by exempting health benefits from taxation will be about \$262.5 billion in 2010. This includes \$157.0 billion in forgone revenues from the income tax and about \$87.2 billion in forgone revenues from the Social Security and Medicare payroll taxes (*Figure A-3*). Under the McCain proposal, the portion of the exclusion associated with the income tax only is eliminated.

**Figure A-3**  
**Federal Tax Expenditure for Employer-Sponsored Insurance (ESI): 2010**



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

The employer benefits exclusion from payroll taxes would be retained.<sup>1</sup> The deduction for costs over 7.5 percent of income and flexible benefits health reimbursement accounts would be retained. We assume that the tax credit is available only to those who are not otherwise covered under Medicare or TRICARE (military retirees and dependents). In keeping with this, we assume that the tax exclusion for retiree benefits is retained for the Medicare-covered population.

<sup>1</sup> Communication with Douglas Holtz-Eakin, Senior Policy Advisor, McCain Campaign.

The current tax policy has raised questions of tax equity. For example, a worker who does not have employer coverage and purchases non-group coverage on their own receives no tax benefit. Also, the tax exclusion benefits only those with incomes large enough to be required to pay taxes. The value of the exclusion to the worker increases at higher incomes where marginal tax rates are highest. As shown in *Figure A-3*, about 46.5 percent of the tax exclusion benefit goes to people with incomes of \$100,000 or more. Less than 3.0 percent goes to families with under \$20,000 income.

The tax credit corrects these inequities by making the credit available to anyone who purchases private health insurance, including both employer and non-group coverage. The proposal also provides a fixed dollar tax credit to all of those with private insurance at all income levels, which shifts more of the tax subsidy to lower-income groups.

### *3. Create Incentives to Control Costs*

Many economists argue that the current tax exclusion for employer-provided health benefits encourages over-use of the health care system by encouraging the purchase of comprehensive policies with little incentive to contain costs. The tax exclusion artificially reduces the price of health care relative to other uses of income, which causes employers to purchase overly comprehensive coverage that enables insured patients to over-consume care, thus driving up health care costs.

A major criticism of employer-sponsored insurance (ESI) is that the employer selects the health plan and coverage features of the policy rather than the consumer. Workers often do not even know how much their insurance costs. The tax exempt status of coverage further insulates individuals from the true cost of their health care.

A key feature of the McCain tax credit is that it is a fixed dollar amount regardless of the amount paid for insurance. This differs from the tax exclusion where the higher the premium is, the greater the tax benefit becomes. Thus, under current law, electing a less costly health plan actually reduces the amount of tax subsidy the individual receives. By comparison, with the flat tax credit, consumers can choose a lower cost plan without losing any of the tax benefit. In fact, under the McCain proposal, people who can obtain coverage for less than the amount of the credit are permitted to retain the difference as a deposit in a Health Savings Account (HSA).

### *4. Breaking the Constraints of Employer-Sponsored Coverage*

The McCain proposal is designed to assist people in obtaining coverage that is independent of their job. As discussed above, consumers typically have little choice in the health benefits they are offered at work and have no opportunity to save by taking a lower-cost plan. For example, many workers could be willing to enroll in a lower-cost health plan such as an HMO or a high deductible plan with an HSA. However, if the employer does not offer these options, they must take the coverage selected by the employer.

Under the tax credit plan, the worker is permitted to apply the tax credit towards the purchase of any plan they wish in the non-group market. Thus, workers can decline coverage under their employer's health plan and purchase other coverage using the tax credit. This gives workers greater freedom in selecting their source of coverage. Because they receive the full value of the

credit regardless of the plan chosen, it permits people to purchase more efficient and less costly coverage without forgoing any tax benefit.

As demonstrated below, it is unlikely that people will find it less costly to shift to an alternative source of coverage unless they can take the value of the employer contribution for health benefits with them to help pay their premium. However, because the tax benefit is available for purchase of non-group coverage, employers could “cash out” their health benefits by discontinuing their coverage and giving the worker the amount saved as increased wages, without forgoing the worker’s tax subsidy.<sup>2</sup>

In fact, employers have been moving towards the concept of a defined contribution for health benefits for several years. The fact that workers would lose the tax benefit if the employer cashes out the benefit has been a major impediment to making these changes.

### *5. Portability of Coverage*

Enabling people to purchase policies on their own with the help of the tax credit enables people to stay with their current health plan when they change jobs or leave the labor force. Under the Health Insurance Portability and Accountability Act (HIPAA), employers are required to cover all new hires without pre-existing conditions as long as they have maintained coverage for the prior 12 months which assures a kind of portability for workers. However, when people are purchasing coverage in the non-group market, they can change jobs without actually moving to a new health plan, which can be described as true “portability.”

## **B. Permit the Sale of Coverage Across State Lines**

Under the McCain proposal, insurers are permitted to sell insurance across state lines. This means that the insurance regulations that apply are those of the “primary state” of operations selected by the carrier rather than those of the state in which the policy is actually sold. One of the primary effects of this provision would be to preempt mandatory benefits requirements in states with mandates, thus making lower cost policies available in many states.

This provision would also have the effect of “deregulating” insurance rating practices in states that place limits on the amount of variation in premiums by age, health status, and other risk factors. Thus, for example, an employer in a state with community rating - which requires insurers to charge a single uniform rate for all applicants - could purchase coverage from an out-of-state source where premiums are permitted to vary with age or health status.

Allowing employers to purchase coverage across state lines would enable firms with younger and healthier workers to obtain coverage at a lower premium while causing premiums to increase for employers with older and sicker members.

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<sup>2</sup> The McCain campaign does not specify a floor for actuarial value or a minimum benefits package that would qualify for the tax credit.

## 1. Background

Under the Employee Retirement Income Security Act (ERISA), states are prohibited from regulating self-funded group health insurance plans. These are plans where the employers bear the full risk of costs for covered benefits for their groups. However, states retain the prerogative to regulate fully-insured groups, which are groups for which the insurer is fully at risk for a covered group's costs. For these groups, the state may regulate the types of services offered and the way in which premiums are determined, and they may impose a tax on premiums.

All of the states regulate at least some aspect of the sale of insurance to individuals in the non-group and small group (i.e., 50 or fewer workers) markets, and many regulate insurance for larger fully insured groups as well. Most states require that health plans cover a list of mandatory benefits such as mental health, substance abuse, chiropractic care and other services. In some instances, the states require that, if a given service is covered, it must meet a set of standards specified in a statute. States also impose plan solvency rules. Other regulations may establish minimum requirements for grievance and appeal procedures, protect against unfair marketing practices, and ensure timeliness of claims payments.

Most states have adopted at least some regulations on how premiums are determined in the individual and small group markets. These rules generally achieve some degree of "rate compression" by limiting the extent to which insurers can vary premiums with health status or other factors. States generally require greater degrees of rate compression in the small group market than in the individual market.

For example, in New York and Vermont, insurers are required to use "pure community rating" in both the individual and the small employer markets. This means that the premium charged by an insurer must be the same for all people buying these benefits in the same geographic area, regardless of risk characteristics. Another seven states (Maryland, Washington, Connecticut, Maine, Massachusetts, New Jersey, and Oregon) permit insurers to vary premiums for employers by age, gender, and industry, but do not permit premiums to vary with health status. Other states permit premiums to vary with health status as well, but often place limits on the extent to which premiums may vary with health status (e.g., 35 percent above and below the average premiums for a given rating group such as age).<sup>3</sup>

The Health Insurance Portability and Accountability Act (HIPAA) required insurers to guarantee issue of insurance to employers whose employees have maintained their coverage for at least the past 12 months. However, in all but six states, insurers are permitted to deny coverage in the individual market due to health status.<sup>4</sup>

In 34 of the states that permit denials of coverage in the individual market, the state sponsors a high-risk pool that accepts those who have been denied coverage. These high-risk pools typically charge a premium equal to 150 percent or more of the average cost of insurance for the

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<sup>3</sup> Most states also impose a tax on the sale of health insurance typically between 1% and 2% of the premium.

<sup>4</sup> Insurers in Ohio are required to guarantee issue individual market coverage but can eliminate or restrict coverage for certain conditions.

general population for someone of the applicant's age. Because losses typically exceed premium collections for this group, these pools are typically financed with an assessment on insurance or some other financing mechanism.

In most states, premiums in the individual market for someone of a given age are typically lower than premiums for comparable insurance in the small group market for groups with similarly aged members. The reason for this is that insurers can decline to cover people with a health condition in the individual market but are prohibited from doing so in the small group market. Consequently, the premiums in the individual market are lower because they exclude higher cost people, who typically take coverage in the high-risk pool.

## *2. Small Group Market Impacts*

Under the bill, carriers are permitted to sell policies across state lines where the insurance regulations that apply are those of the "primary state" of operations selected by the carrier rather than those of the state in which the policy is sold. The primary effect of this would be to pre-empt mandatory benefits and insurance market regulations in individual states.

For example, a carrier declaring Delaware as their primary state of operations would be able to sell small group policies to employers in New York that comply only with regulations in Delaware rather than the more extensive regulations that now apply in the New York small group market. Thus, the Delaware-based carrier would be able to sell policies that do not include many of the mandatory benefits required in New York. Carriers could also sell policies that are rated on the basis of age and health status as allowed in Delaware rather than with the community rating rules that now apply in New York.

This would generally reduce the cost of insurance for firms purchasing out-of-state coverage that does not include state mandated benefits (e.g., mental health, maternity care, fertility treatment, substance abuse, chiropractic care, etc.). In a study of a similar proposal, the Congressional Budget Office (CBO) assumed that premiums would be reduced by about 5.0 percent by avoiding these mandates.<sup>5</sup>

The bill would also tend to undermine rate compression rules and other restrictions on insurer rating practices that many states have implemented. The effect would be greatest in states that have prohibited the use of health status in rating premiums for the individual insurance market, including: Connecticut, Maine, Massachusetts, New Jersey, New York, Oregon, Vermont, and Washington. This would result in lower premiums for firms with younger and healthier workers while tending to increase premiums for firms with older and sicker members.

## *3. Impact on Individual Coverage*

Permitting the sale of insurance across state lines would have less of an impact in the individual market. As in the small group market, bypassing state mandatory benefits requirements would reduce the cost of insurance by about five percent. However, it would affect rate compression

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<sup>5</sup> Baumgardner, J., et al., (2000, January). "Increasing Small-Firm Health Insurance Coverage through Association Health Plans and Health Marts," Washington, D.C.: Congressional Budget Office.



primarily in the states with community rating in the individual market. It would also have a smaller impact in other states that have adopted limitations on premium variation by age and health status.

### C. Establish a Guaranteed Access Plan (GAP)

The McCain proposal acknowledges that people who have not maintained group coverage or have pre-existing health conditions may not be able to obtain coverage in the individual market. McCain proposes to work with states to establish a Guaranteed Access Plan (GAP) charged with assuring that coverage is available to people who have been denied coverage in the individual market. He proposes to base the plan on state “best experience” in assuring access to coverage.

The campaign suggests establishing a non-profit corporation that would contract with insurers to cover people who have been denied coverage, which is similar to the way many of the existing high-risk pools now operate. The McCain campaign indicates that the program would have reasonable limits on premiums and assistance would be provided to people below a designated income level.

The McCain plan does not provide any more detail than this on how the plan would be structured. For illustrative purposes, we have specified a program that assures access to coverage for all of those who are denied coverage in the individual market that is consistent with their proposal.

We assume that GAP would take the form of a high-risk pool in each state that is available to all who have been denied coverage due to health status. Existing state high-risk pools would be absorbed into the GAP. We assume that participants would pay a premium equal to 150 percent of “standard risk,” which is an estimate of the premium for an average individual (in and out of the pool) of the applicant’s age. We assume that losses under the pool would be paid for with an assessment on the individual market sufficient to pay for 50 percent of the program. The federal government would pay the remaining 50 percent.<sup>6</sup>

In addition, the McCain plan would provide subsidies to low income people who enroll in the high-risk pools. Because the campaign has not specified these subsidies, we adopted a specification that is consistent with what has been described. We assume that high-risk pool applicants with incomes below 150 percent of the federal poverty level (FPL) would be required to pay a premium equal to 100 percent of standard risk, rather than the 150 percent of standard risk charged to others in the pool. This has the effect of capping the premium for these people at roughly the same level paid by people with similar incomes who do not qualify for the pool. We assume that the subsidy phases out on a sliding scale with income between 150 percent and 300 percent of the FPL.

We simulated the impact of the policy on insurance coverage in the small group market using the insurance market modules of The Lewin Group “micro-simulation” model of the US health

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<sup>6</sup> Communication with Douglas Holtz-Eakin, Senior Policy Advisor, McCain Campaign.

care system called the Health Benefits Simulation Model (HBSM). This was done in the following steps:

- **Firm coverage decision:** We simulated the number of firms facing increased premiums who discontinue coverage based upon econometric models showing how the likelihood of an employer offering ESI is affected by changes in premiums. Similarly, we simulate an increase in the number of firms offering coverage due to a reduction in the premiums they would pay for coverage;
- **Individual coverage effects:** For people in affected firms, we estimated changes in coverage on enrollment in non-group plans based upon similar econometric models of how changes in the cost of insurance affects the likelihood of taking coverage; and
- **Medicaid Enrollment:** HBSM simulates changes in enrollment for Medicaid for affected people using the actual income eligibility levels used in each state and econometric models of the likelihood that eligible people will enroll (about 70 percent for families).

#### D. Simulation of Coverage and Costs

The cost and coverage effects of the McCain proposal would be far reaching and complex. Permitting insurers to sell coverage across state lines would effectively “deregulate” insurance resulting in lower premiums for employer groups with younger and healthier people and higher premiums for groups with older and sicker people. This would be true of the individual market as well for people in the few states that now require substantial rate compression in that market.

The McCain plan would reduce employer coverage. Replacing the employer health benefits exemption with a tax credit that is available for both employer and non-group coverage would reduce the relative cost advantage of having ESI. In fact, the McCain proposal actually favors non-group coverage by creating federally subsidized high-risk pools that would cover individuals in the non-group market who have high-cost chronic conditions.

The plan could also result in a reduction of employer coverage even in those firms that continue to provide ESI. This is because the proposal enables younger and healthier workers to decline ESI and purchase lower-cost coverage with the help of the tax credit in the non-group market.

Our analytic approach was to use HBSM. The model is based upon a survey of households and a separate survey of employers. We use the model to determine the cost of insurance to individual families and groups under the current system and under the new system defined in the McCain proposal. The model then simulates coverage decisions for families and groups given the change in financial incentives created by the plan.

Because the effects of the plan are complex, we broke the analysis down into five steps that enable us to model the effect of the new incentives under the proposal on individual and employer group coverage decisions. The process is repeated in an iterative process that measures how these coverage decisions affect cost and premiums in the individual and employer risk pools. *Figure A-4* presents our estimates of transitions in health insurance coverage under the McCain proposal once fully implemented.



Figure A-4  
Transitions in Coverage under the McCain Plan in 2010  
(thousands)

		Coverage Under the McCain Plan								
		Private Coverage				Public Coverage				
Coverage Under Current Law		High Risk Pools	Employer	Individual non-group	Retiree	TRICARE	Medicare	Medicare & Medicaid Dual Eligibles	Medicaid & SCHIP	Uninsured
Employer Workers and Dependents	153,801	2,468	137,663	8,153	-	-	-		1,237	4,280
Private Non-Group	14,252	581	803	12,787	-	-	-		-	81
Employer Retiree	3,647	-	-	-	3,647	-	-	-	-	-
TRICARE	6,044	-	-	-	-	6,044	-	-	-	-
Medicare	32,179	-	-	-	-	-	32,179	-	-	-
Medicare & Medicaid Dual Eligible	6,750	-	-	-	-	-	-	6,750	-	-
Medicaid and SCHIP	41,466	-	430	-	-	-	-	-	41,036	-
Uninsured	48,918	2,717	5,474	17,257	-	-	-		-	23,470
Total	307,057	5,766	144,370	38,197	3,647	6,044	32,179	6,750	42,273	27,831

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

The primary steps in modeling the plan's impact on coverage are described in the following sections:

- Premiums in the individual market;
- Employer response to new rating rules;
- Impact of the tax credit on employer coverage;
- Changes in worker plan participation; and
- Iterative simulation of coverage choices.

### *1. Premiums in the Individual Market*

As described in *Appendix C*, the Lewin model is based upon a representative sample of families in the Medical Expenditures Panel Survey data (MEPS), which provides detailed information on sources of coverage, family income, health conditions, utilization, and health spending. Using these data we identify people who are in the individual insurance market, which we define to include the non-Medicare population currently with individual insurance and uninsured people who are not offered coverage at work.

We then simulate premiums for these in the individual market for a standard benefits package.<sup>7</sup> We did this by computing a “rate book” similar to those that might be used by an insurer. The rate book shows how costs for a given benefits package varies with key rating factors such as age, gender, experience, and presence of a chronic condition. A separate rate book is created for each state based upon the rating rules that apply in the state and the presence of a high-risk pool.

We base the rate books on costs for privately insured people in the MEPS.<sup>8</sup> The MEPS data permit us to measure how costs vary by age of policy holder (single year of age), gender, industry, single/family coverage, and experience using a tiered rating system. The rate book is also tailored to reflect the unique features of a state's rating system. Key steps include:

- **Guaranteed issue provisions:** In states requiring community rating in the individual market, we base the premiums on costs for all privately insured people including people with chronic conditions;
- **Medical underwriting provisions:** In states that do not require guaranteed issue, we set individual market premiums by excluding people who report that they have one of several chronic conditions typically screened for in the medical underwriting process;
- **High-risk pool rating:** In the 34 states with a high-risk pool, we set the premium for people with chronic conditions based upon the rate setting rules used in each state. For example, in a state setting high-risk pool premiums at 150 percent of “standard risk,” we

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<sup>7</sup> We assume the standard benefits package to be the Blue Cross Blue Shield Standard Option benefits package that is available to federal workers under the Federal Employees Health Benefits Plan (FEHBP).

<sup>8</sup> Due to data limitations, the rate book for any given state is based upon costs reported by all privately insured people in the survey.

set the premium equal to 150 percent of the overall average cost of insurance in the general population by individual year of age;

- **Health status rating:** We simulate health status rating using a tiered rating system. We estimate “expected costs” for each individual based upon health spending for privately insured people, based upon analysis of how costs in a year are expected to vary with the amount spent for care in the prior year;<sup>9</sup> and
- **Rate compression:** In states that limit premium variation with health status, we set premiums using a simplified rating band approach.

We then estimated premiums for each individual in the individual market using the rating rules that would apply under the McCain proposal. This affected primarily states that do not currently use health status rating. It also reflects the high-risk pools created under the GAP program proposed in the McCain plan, which essentially extends high-risk pools to each of the states that do not now have them.

We simulated the effect on coverage based upon the change in premiums they would experience under the program. We simulated the percentage of people taking coverage based upon an estimated “price elasticity,” which is a measure of the percent change in the number of people with coverage given a one percent change in premiums. The average price elasticity is about -0.34, but varies with age and income.

Using this approach we estimated the number of people taking coverage in the individual market under the proposal. A portion of the uninsured experiencing a reduction in premiums would take-up coverage, while a portion of those experiencing an increase in premiums would discontinue coverage. We estimate a net increase in non-group coverage of 2.4 million people (*Figure A-5*). The estimated impact on coverage is small since most states currently permit medical underwriting and 34 states already have high-risk pools.

## *2. Employer Response to New Rating Rules*

Allowing the sale of insurance across state lines would have the effect of reversing much of the rate compression required under current rating rules. This means that in states that now restrict rating practices in the small group market, small employers with younger and healthier workers would be able to obtain coverage at lower premiums than they would now be required to pay. However, this would tend to drive up premiums for people with older and sicker workers by removing lower cost groups from the “in-state” insurance pool.

The degree to which these changes would actually affect premiums for small employers is difficult to estimate. For example, some large in-state insurers will have extensive provider networks with significant provider discounts that can not be matched by out-of-state carriers with a minimal market share in the state. Thus, the coverage offered by in-state carriers could still be quite competitive. However, over time, the loss of lower cost groups from the in-state market is likely to result in an overall increase in premiums for in-state carriers that would

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<sup>9</sup> These estimates were developed based upon MEPS data for 1996 showing health spending for individuals over two consecutive years.

create pressure for states to relax rating restrictions so that in-state carriers can remain competitive.

**Figure A-5**  
**Change in Coverage in the Non-group Market due to Permitting the**  
**Purchase of Coverage across State Lines**  
 (thousands)

	Change in the Number of People with Non-group Coverage	
	Change in Rating Practices	With Changes in Rating and Mandatory Benefits
Number of People Discontinuing Non-group Coverage	875	767
Number of People Taking Non-group Coverage	2,588	3210
Net Change in the Number of People Taking Non-group Coverage	1,713	2,443

a/ Estimates reflect the change in rating practices only and do not reflect the tax credit.  
 Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

We modeled the effect that this would have on coverage using the small group rating model in HBSM. Our approach is to estimate the cost of insurance to each employer group in the model, including insuring and non-insuring firms, under current rating practices in their state of residence and again under the least restrictive small group rating rules in the country. *Figure A-6* presents the distribution of workers in small firms by the amount of the change in per worker premiums for their employer.

We then used an econometric model of how changes in premiums affect the likelihood of an employer offering coverage given the estimated change in their premium to simulate the employer decision to offer or discontinue coverage. Our model shows a price elasticity of about -0.87 for firms with fewer than 10 workers. This means that an increase in the premium of one percent is associated with a 0.87 percent reduction in the number of small employers offering coverage. The price response drops sharply as firm size increases.

The analysis is based upon a sample of employers in the 2006 Kaiser Family Foundation (KFF) survey of health plans which provides coverage, cost, and limited benefits information for each employer. These data were statistically matched with the 1997 Robert Wood Johnson Foundation survey of employers which provides information on the demographic characteristics of workers in each employer group. For each employer, we populate the group with workers in the MEPS data in proportion to the distribution of an employer's workforce by age, earnings, part time/full time status, gender, and type of coverage.

**Figure A-6**  
**Changes in Premiums for Workers in Small Firms by Age of Worker under the McCain Plan**

Change in Monthly Premium	Workers (1,000s)	Percent of all Workers	Under age 25	25 - 34	35 - 44	45 - 54	55 or Older
<b>Family Coverage</b>							
Decrease \$200 or more	456	5.6%	4.8%	5.1%	4.8%	6.3%	6.4%
Decrease \$100 - \$199	422	5.2%	8.5%	5.9%	5.6%	5.4%	2.8%
Decrease \$50 - \$99	282	3.5%	2.7%	3.7%	3.0%	3.2%	4.4%
Decrease \$20 - \$49	4,115	50.4%	46.9%	52.9%	49.4%	50.8%	49.8%
No Change +/- \$20	1,025	12.6%	12.4%	13.8%	12.4%	14.0%	9.5%
Increase \$20 - \$49	351	4.3%	5.4%	3.3%	5.3%	2.7%	6.0%
Increase \$50 - \$99	317	3.9%	7.3%	3.8%	4.5%	3.7%	2.6%
Increase \$100 - \$199	569	7.0%	6.0%	5.7%	7.5%	7.5%	7.1%
Increase \$200 or more	620	7.6%	6.0%	5.8%	7.6%	6.4%	11.5%
Total Family	8,157	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<b>Single Coverage</b>							
Decrease \$200 or more	116	1.3%	0.9%	1.2%	0.6%	2.2%	1.5%
Decrease \$100 - \$199	679	7.4%	6.3%	6.5%	7.9%	7.4%	9.2%
Decrease \$50 - \$99	691	7.5%	8.7%	7.9%	8.2%	6.0%	6.8%
Decrease \$20 - \$49	377	4.1%	4.9%	5.5%	3.1%	3.7%	3.0%
No Change +/- \$20	5,795	63.2%	64.2%	63.4%	65.1%	62.0%	60.8%
Increase \$20 - \$49	524	5.7%	5.9%	4.9%	5.7%	6.7%	5.4%
Increase \$50 - \$99	526	5.7%	6.7%	6.2%	5.0%	4.5%	6.2%
Increase \$100 - \$199	356	3.9%	2.0%	3.4%	3.9%	5.6%	4.6%
Increase \$200 or more	112	1.2%	0.3%	1.0%	0.5%	2.1%	2.4%
Total Single	9,176	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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

For each of these firms, we estimate the premium they would be charged for a given benefits package given the characteristics of their workforce and the rating rules used in each state. The small group insurance model estimates premiums for each firm using a “rating book” similar to that described above for the individual market. The model simulates age, gender, and industry rating. It also simulates how premiums vary with health status based upon an estimate of expected costs given each worker’s spending in the prior year.

The model simulates the rate compression required in the small group market under the rating rules used in each state. For example, in one state premiums are community rated and vary only by family status. Another seven states used “modified community rating” which permits rating by age but not by health status. Most states also place limits on the degree of premium

variation allowed. *Figure A-7* summarizes the variation in per-worker premiums for currently insuring firms in 2006 for a standard benefits package.<sup>10</sup>

We simulated the premiums individual groups would be charged under the rules used in the least restrictive state in the nation. Using the price elasticity estimates discussed above, we simulated the decision to discontinue coverage in cases where premiums increase for currently insuring firms, and the number of non-insuring employers who would now offer coverage for firms who would see a reduction in premiums they would face in the small group market.

Finally, we estimate that some currently uninsured workers would take coverage on their employer's plan. Using the MEPS data, we estimate that there are about 4.0 million uninsured workers who have declined the coverage available to them at work. We estimate that some of these workers would enroll in their employer plan in instances where the cost of doing so is reduced under the McCain proposal. Because many of these workers have relatively low incomes, the tax credit will be much more than the value of the employer exclusion, which could cause them to take the coverage. We modeled this on the basis of the individual price elasticity estimates discussed above (average elasticity of -0.34).

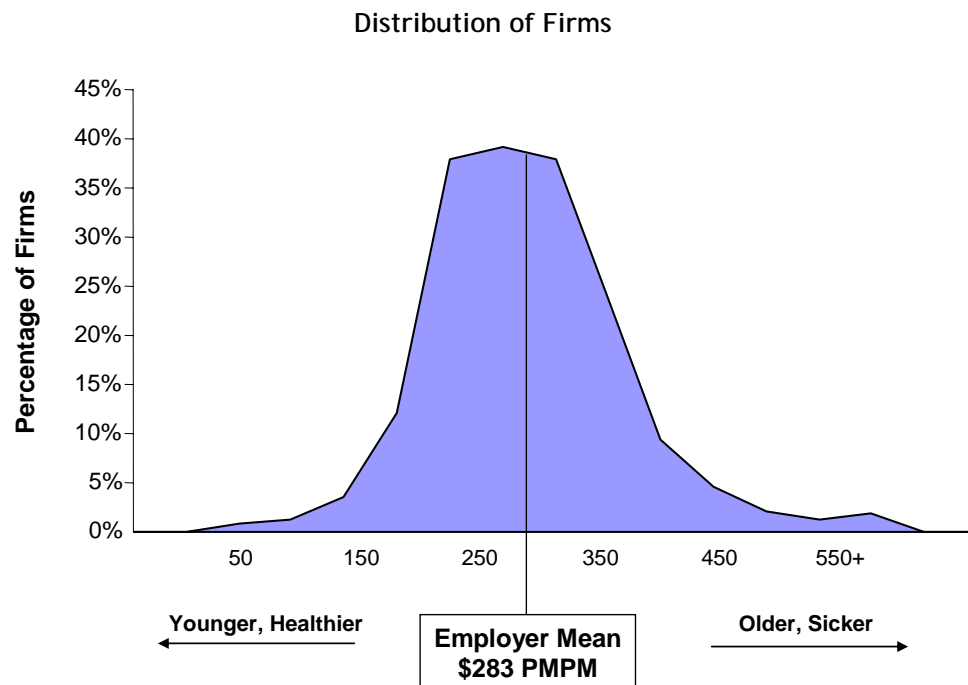
As shown in *Figure A-8*, the number of workers and dependents with employer-sponsored insurance would increase by about 2.1 million people due to changes in rating rules and reduced costs for mandated benefits. We estimate that about 690,000 workers and dependents would lose coverage in firms that decide to discontinue their plans in response to increases in premiums resulting from permitting the sale of insurance across state lines. However, about 1.8 million people would take Employer Sponsored Insurance (ESI) in firms where premiums fall by allowing cross-state sale of insurance.<sup>11</sup> Also, about 1.0 million people who have declined the coverage offered through work would now take the coverage due to these changes in rating practices. These primarily include workers and dependents in firms with a younger and healthier workforce. These estimates also reflect premium reductions due to the availability of insurance with fewer mandatory benefits.

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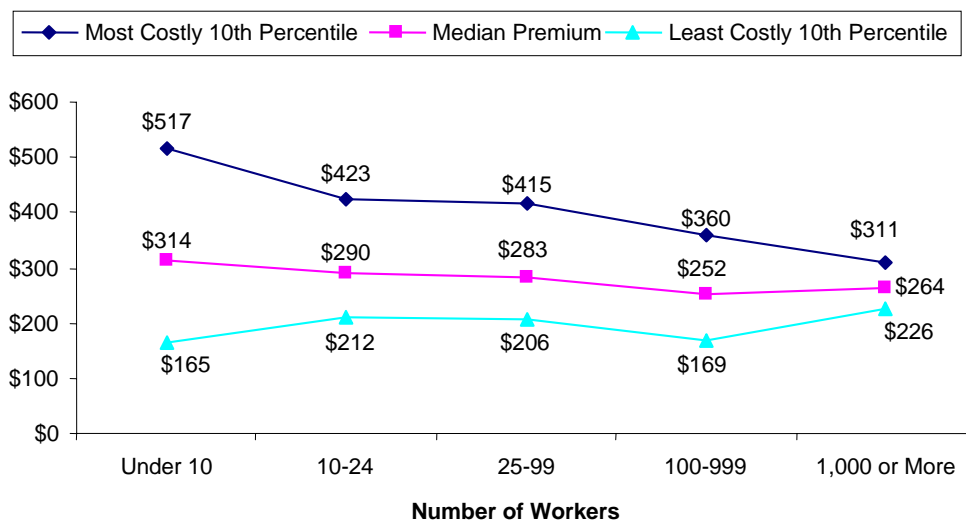
<sup>10</sup> The premium paid for the benefits package actually offered by the employer is estimated by adjusting the premium for a standard benefits package based upon the estimated actuarial value of the employer's plan.

<sup>11</sup> The model simulates the price of insurance in an iterative process based on the risk characteristics of individuals in the rating pool. Premiums are continually adjusted to reflect the migration of individuals into the pool.

Figure A-7  
Estimated Employer Premium Costs per Member per Month for Currently Insuring Firms in 2006 <sup>a/</sup>



**PMPM Costs for Most Costly and Least Costly 10 Percent of Groups**



a/ Estimates for a standard benefits package including benefits and administration.  
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).



Figure A-8  
Change in Employer Coverage Under The McCain Plan in 2010  
(thousands)

	Workers and Dependents in Currently Insuring Firms		Workers and Dependents in Non-Insuring Firms That Decide to Offer Coverage	Net Change in Employer Coverage
	Firms that Discontinue Coverage	Workers Who Previously Declined Coverage Who Take Coverage		
1. Change in Premium Rating Rules and Mandatory Benefits	-690	1,011	1,801	2,122
2. Change in Tax Incentives and Impact of Federal High-Risk Pool Funding	-11,928	3,702	193	-8,033
3. Individual Worker Response to Tax Incentives	-3,520	0	0	-3,520
<b>Combined Impact</b>	<b>-16,138</b>	<b>4,713</b>	<b>1,994</b>	<b>-9,431</b>

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

### 3. Impact of the Tax Credit on Employer Coverage

The McCain plan reduces the cost of non-group coverage relative to employer-sponsored coverage, which is likely to cause some employers to discontinue benefits. The plan replaces the existing tax exemption for employer-provided benefits with a tax credit that can be used for either employer or non-group coverage. This largely eliminates the after-tax cost advantage of employer coverage. Also, the GAP program provides subsidies to high-risk pools that effectively lower the cost of coverage for people who continue in the private insurance pool (e.g., people without chronic conditions), which has the effect of further reducing the cost of non-group coverage.

These changes in the relative cost of employer vs. non-group coverage are expected to cause some employers to discontinue their coverage. However, any analysis of the employer response to the McCain plan must begin with acknowledging that there is nothing preventing employers from discontinuing coverage right now. They maintain their plans because they need to provide health benefits to attract and retain good workers. Consequently, we assume that employers will continue to seek the most efficient compensation package possible for their work force.

We simulated the employer response to these changes by estimating the cost of coverage for their workforce if they purchase employer coverage and comparing it with what it would cost for these workers to obtain coverage in the individual market. The cost of employer coverage is estimated for each firm assuming employers are allowed to purchase coverage across state lines as proposed by McCain. We then estimate the cost of purchasing the same benefits package in the individual market under the McCain model. We then simulate the employer's decision to discontinue health benefits in cases where their workers can on average purchase coverage in the individual market at a lower cost.



We estimated the cost of covering a group with employer coverage under the McCain plan as described above, less the amount of the tax credit that would be received by each worker. We estimated the premium for each individual in the individual market using the individual market model as described above net of the credit they would receive. This calculation of costs in the individual market reflects the following:

- **High-risk pool:** The members of the group with a prior health condition are assumed to pay only the age-specific premium for the high risk pool, which is about 150 percent of standard risk. This will often be substantially less expensive than the full cost of covering them under the employer plan;
- **High risk pool low-income subsidies:** As discussed above, the McCain plan would subsidize the cost of purchasing coverage from the GAP high-risk pools for those with low incomes. We assume that the program would pay about one-third of the high-risk pool premium for people living below 150 percent of the FPL and be phased out through 300 percent of FPL; and
- **Administrative costs:** The premium estimates reflect that individual insurance is substantially more expensive to administer than group coverage. Administration for non-group coverage averages about 35 percent of benefits costs compared with about 20 percent of claims for small groups and as low as 3.5 percent of claims for firms with over 10,000 workers.

We assume that the employer contribution for health benefits would be paid in cash to workers if the employer discontinues coverage, so that the coverage choice is based only upon the actual cost of coverage in either the small group or individual markets, net of tax credits.

Some employers will see significant reductions in premiums if they purchase coverage through the individual market. We estimate that removing people with chronic conditions from the individual market reduces premiums for the healthier individuals who remain in the individual market by about 35 percent. Thus, the premium for a group with no members that have a chronic condition would tend to be much lower than the rates the employer would be charged if they covered them as a group. People with chronic conditions would also cost less in the individual market due to the premium subsidies.

However, in many cases, premiums still will be less costly in the small group market due to the lower cost of administering coverage to groups.

We identified employers where total insurance premium costs, after accounting for the McCain tax change, would be lower if the workers were to purchase coverage on their own. We estimate the portion of these who would discontinue coverage based a statistical analysis of the likelihood of changing to a lower cost plan when available. These data show an overall average price elasticity of -2.47, which means that 1 percent lower premium results in about 2.47 percent shifting to the lower cost health plan. The elasticity ranges from -3.5 for people under the age of

31 years who are a low health care risk to -1.38 for high risk individuals over the age of 45 years.<sup>12,13</sup>

Using this approach, we estimate that about 11.9 million workers and dependents would be in firms that decide to discontinue coverage (*Figure A-8*). This would be partially offset by an increase in enrollment among eligible workers in currently insuring firms of about 3.7 million people due to the availability of the tax credit. These are workers and dependents that are offered coverage through work who have declined coverage under current law who would now take the coverage with the help of the tax credit. Thus, we estimate a net loss of coverage of about 8.0 million people due to the availability of lower cost coverage in the non-group market and the availability of the tax credits.

Once an employer has dropped coverage, we simulate the enrollment of affected workers and their dependents in other forms of coverage. Some of these individuals will qualify for Medicaid and would be enrolled. We also estimate the likelihood that workers who lose employer coverage will actually purchase non-group coverage. We do this based upon the difference between the worker's out-of-pocket premium payment under their former employer plan and the premium they would pay in the non-group market, less the tax credit amount.

#### 4. Changes in Worker Plan Participation

Individual workers in firms that offer coverage will still have the option of using their tax credit to purchase coverage in the individual market. As discussed above, the premium for non-group coverage would on average be about 35 percent lower than the premium for coverage in the small group market. Young people in particular will often be able to purchase coverage in the non-group market with the credit for less than if they took the coverage through their employer. Also, they avoid paying taxes on the employer health benefit if they decline the coverage.

We simulated this by estimating the net cost of coverage for each individual under both options. The cost of employer coverage to the individual includes the employee share of the premium and the taxes paid on the employer benefit less the amount of the tax credit. If the individual takes coverage in the individual market, their cost of coverage is equal to the premium for the non-group coverage less the amount of the tax credit. It does not include the tax on the employer benefit because they would not be taking the benefit.

Some of those who would find the cost of non-group coverage lower than their cost of taking the employer plan were simulated to do so. We estimated the shift to non-group coverage based upon the plan-change price elasticity estimates described above. We estimate that about 3.5 million such workers and dependents would drop employer coverage in this way (*Figure A-8*).

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<sup>12</sup> Strombom, Bruce A., Buchmueller, Thomas C., Feldstein, Paul J., "Switching Costs, Price Sensitivity and Health Plan Choice," *Journal of Health Economics*, October 2001.

<sup>13</sup> We calculate an overall average plan switching elasticity by taking the average price elasticity for individual group members given their distribution by age and risk status.

### 5. Iterative Simulation of Coverage Choices

The premiums charged to individuals and small employers are dependent upon the cost characteristics of those enrolling in the various forms of coverage. Thus, the premiums estimated above must be adjusted to reflect the actual cost profile of those who enroll in each market. However, these changes in premiums would result in changes in the number of people enrolling. Thus, the premium levels are dependent upon those enrolling, while enrollment is dependent upon the premium.

We simulate the interdependence of premiums and coverage decisions by rerunning the simulation in an iterative process where the premiums are updated each time to use the premium estimated from the results of the prior iteration. This step is repeated several times until the premiums and coverage converge to a steady solution. As shown in *Figure A-8*, we estimate that there would be a net loss of employer coverage of 9.4 million people. *Figure A-9* presents the changes in employer health spending by current insuring status under the McCain plan.

**Figure A-9**  
Change in Private Employer Health Benefit Costs by Current Insuring Status  
Under the McCain Plan in 2010 (billions)

	Currently Insuring Employers	Currently Non-Insuring Employers	All Employers
<b>Private Employer Spending Under Current Policy</b>			
Current Cost of Coverage			
Workers and Dependents	\$421.7	\$0.0	\$421.7
Retirees	\$28.4	\$0.0	\$28.4
<b>Total Current Law</b>	<b>\$450.1</b>	<b>\$0.0</b>	<b>\$450.1</b>
<b>Private Employer Spending Under the Policy</b>			
Costs for Workers Who Retain Coverage	\$372.1	\$0.0	\$372.1
Costs for Workers who Previously Declined Coverage	\$12.1	\$0.0	\$12.1
Costs for Newly Eligible Workers	\$0.0	\$3.2	\$3.2
Costs for Retirees	\$28.4	\$0.0	\$28.4
Health Care System Savings Initiatives	(\$9.1)	(\$0.2)	(\$9.3)
Savings from Reduced Cost Shifting	(\$1.6)	\$0.0	(\$1.6)
Savings From Reduced Mandatory Benefit Requirements	(\$3.7)	(\$0.1)	(\$3.9)
<b>Total Spending Under The Policy</b>	<b>\$398.2</b>	<b>\$2.9</b>	<b>\$401.1</b>
<b>Net Change in Private Employer Spending</b>			
<b>Net Change</b>	<b>(\$51.9)</b>	<b>\$2.9</b>	<b>(\$53.0)</b>

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

## E. Medicaid Opt-out Provisions

As discussed above, the McCain proposal would allow states to use Medicaid funds to enable purchase of private insurance by eligible families. States could use the tax credit and Medicaid program funds to purchase the coverage.

We assume that Medicaid-eligible beneficiaries have the option to obtain private coverage using the tax credit. We also assume that the Medicaid program would cover the premium amount in excess of the tax credit for each individual. We assume that the federal matching rate on state expenditures for these people would be the same as under current law.

This provision would create a financial incentive for states to enroll beneficiaries in private insurance with the help of the credit. This is because the cost of covering these individuals is reduced by the amount of the credit available to them under the McCain proposal. The state and federal governments would share in paying the private insurance premium in excess of the tax credit amount.

We assume that the take-up of private insurance would be 33 percent of the non-disabled Medicaid population and 10 percent of the disabled Medicaid population. This assumption is based upon experience with voluntary managed care programs.<sup>14</sup> We assumed no enrollment from the Medicare dual eligible population would occur, as the tax credit under the McCain proposal would not be extended to Medicare or TRICARE beneficiaries. We assumed this population would stay in the traditional Medicaid plan.

We estimated the cost to the program of shifting the opt-out group to private insurance as follows. We first estimated the average cost of private insurance coverage for the opt-out group using the Health Benefits Simulation Model (HBSM). The subsidy for the purchase of private coverage is the difference between the tax credit and the cost of the coverage. The total cost for the opt-out is the sum of the subsidy and the tax credit (*Figure A-10*).

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<sup>14</sup> This estimate is based upon experience with voluntary enrollment in New York City Medicaid managed care program. Cantor JC, DeLia D, Sandman D, Schoen C., "Voluntary Enrollment in Medicaid Managed Care in New York City: Results from a Household Survey on Risk Selection, Utilization, Access and Satisfaction," United Hospital Fund, New York, NY 10118, USA, *Abstr Book Assoc Health Serv Res Meet.* 15: 238-9.

**Figure A-10**  
**Estimation of Enrollment in Private Health Plans for Medicaid and SCHIP Enrollees**  
**in 2010**

	Number Enrolling in Private Coverage (1,000s)	Current Average Program Cost	Tax Credit for Private Coverage	Actual Program Cost for Opt-out Group <sup>a/</sup>	Cost in Private Market	Premium in Private Market <sup>b/</sup>	Supplemental Payment		Change in Cost	
							Federal Share	State Share	Federal <sup>d/</sup>	State
Medicaid Families	3.9	\$7,628	\$5,000	\$6,621	\$7,210	\$7,210	\$1,238	\$972	\$2,469	(\$1,941)
Disabled	1.1	\$16,106	\$2,500	\$13,980	\$15,224	\$9,750 <sup>c/</sup>	\$4,060	\$3,190	\$9,297	(\$2,960)
<b>Total</b>	<b>5.0</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>

a/ We assume a selection factor of 20 percent from favorable selection into private health plans, of which 7 percent would be corrected for through risk adjustment, leaving a net selection factor of 13 percent.

b/ Assumes that costs under private health plans would be about 32 percent higher than Medicaid costs due to higher provider payment levels and administrative costs. Estimates reflect the reduction in private non-group premiums resulting from expanded coverage under the GAP high-risk pools.

c/ Disabled people are assumed to be enrolled in a high-risk pool where the premium is set at 150 percent of standard risk by age.

d/ Includes the cost of the tax credit, federal subsidies to the high-risk pool for the disabled, and the federal share of payments to health plans. The federal cost includes only the 50 percent of GAP losses covered by the federal government. The remainder of the GAP losses for these people would be covered through the assessment on insurance in the non-group market.

Source: The Lewin Group estimates.

Since this is a voluntary program, we make adjustments for the effects of selection, which we base upon studies of prior voluntary managed care programs under Medicaid. Based upon these data, we would expect the opt-out group to be 20 percent less costly than the Medicaid population.<sup>15</sup> However, given that risk adjustment would reduce the incentive for selection, we assume the opt-out group would be 13 percent less costly than the population remaining in traditional Medicaid.<sup>16</sup>

The federal cost of the program would be the difference between total federal subsidies under the McCain proposal and what the federal government would spend for these individuals under current law. Subsidies under the McCain proposal include the tax credit, the high-risk pool subsidy, and the federal share of the cost of the remaining Medicaid payment (i.e., premium amount in excess of the credit). The savings for states are equal to the state share of remaining Medicaid payments for these people and the state share of what Medicaid would have spent for these individuals under the existing Medicaid program.

Our analysis shows increasing enrollment in the early years of the program with enrollment falling after about 2014. This reflects the fact that the buying power of the tax credit, which is indexed to the Consumer Price Index (CPI) rather than health care costs, would fall over time

<sup>15</sup> Scholle, S.H., "Changes in Medicaid Managed Care Enrollment Among Children," *Health Affairs*, Vol. 16, N 2.

<sup>16</sup> Shen, Y., "How Profitable is Risk Selection? A Comparison of Four Risk Adjustment Models," *Health Econ.* 11:165-174 (2002).

resulting in lower enrollment.<sup>17</sup> The net cost to federal government of providing private coverage would be \$137.2 billion over the 2010 through 2019 period (*Figure A-11*). Provider payments for health services would increase by about \$20.4 billion over this period due to the shift of Medicaid beneficiaries to private insurance.

**Figure A-11**  
**Estimate of Enrollment and Net Cost of Medicaid Private Coverage Opt-out**  
**(Private Coverage Opt-in)**

	Number Opting for Private Coverage (millions) <sup>a/</sup>	Increased Costs to Federal Government	Savings to State Governments	Net Increase in Provider Payments from Private Coverage
2010	5.1	\$2.2	-\$1.3	\$0.3
2011	10.3	\$9.7	-\$5.8	\$1.5
2012	13.0	\$16.3	-\$9.8	\$2.5
2013	12.1	\$16.2	-\$9.7	\$2.5
2014	11.2	\$16.1	-\$9.6	\$2.5
2015	10.2	\$15.7	-\$9.4	\$2.3
2016	9.5	\$15.6	-\$9.4	\$2.3
2017	8.8	\$15.5	-\$9.3	\$2.2
2018	8.0	\$15.1	-\$9.0	\$2.2
2019	7.4	\$14.9	-\$8.9	\$2.1
2010-2014	N/A	\$60.5	-\$36.3	\$9.3
2010-2019	N/A	\$137.2	-\$82.3	\$20.4

a/ We assumed that enrollment would phase-in over a period of three years. We estimate that coverage would gradually decline after the third year reflecting that the buying power of the tax credit declines over time because it is indexed to the CPI rather than health care cost growth.  
Source: The Lewin Group estimates.

## F. Health Care Savings Initiatives

The changes in the tax treatment of health benefits under the McCain plan are designed to make the tax code “neutral” in terms of its effect on health spending. Most economists agree that this would slow health care cost growth. Allowing employers and individuals to purchase insurance across state lines would permit them to buy coverage that is free of the mandatory benefits required in some states, which is also likely to reduce premiums.

The campaign also lists several initiatives that would affect the growth in health spending. These include malpractice reform and a proposal to permit re-importation of prescription

<sup>17</sup> Statement by Jay Khosla, Health Policy Advisor for John McCain on September 18, 2008 conference at George Washington University: "Health policy advisors from the Presidential campaigns will discuss the top health issues in the Presidential race."



drugs. However, too little information is available to assess their impacts, if any. We discuss these effects in the following sections

- System savings from tax policy;
- Savings from elimination of state mandated benefits;
- Prescription drug re-importation;
- Medical malpractice reform; and
- Other savings initiatives.

### *1. System Savings from Tax Policy*

The McCain proposal would replace the current exemption for employer provided health benefits with a flat dollar tax credit of \$2,500 for individuals and \$5,000 for families. A major criticism of the employer tax exclusion is that it artificially reduces the price of health care relative to other uses of income. The amount of the tax subsidy from the exclusion actually increases as the amount paid for insurance increases. This has led to comprehensive coverage that enables us to over-consume care, thus further driving up health care costs.

The tax credit differs in that it is a fixed dollar amount regardless of the amount paid for insurance. Under the flat tax credit, people who can obtain coverage for less than the amount of the credit can enroll in a less costly plan without forfeiting any tax benefit. In fact, if a tax filer obtains coverage for less than the amount of the credit, he or she is permitted to retain the difference as a deposit in a Health Savings Account (HSA). Thus, the McCain tax credit restores incentives for consumers to conserve on their health spending by taking a high-deductible plan or enrolling in a more efficient HMO.

We assume that the taxation of employer-provided benefits would create incentives for people to seek lower cost health care. To quantify the effect, we assumed that the tax the individual would pay on these benefits represents an increase in the perceived price of employer coverage. We estimated the savings from these changes in incentives assuming that this has the effect of moving people to lower cost organized systems of care such as HMOs.

We modeled the number of people shifting to HMOs based on research investigating the effect that increases in price for a given insurance product have on the likelihood of an individual moving to an alternative lower cost health plan.<sup>18</sup> We assumed that savings would be about 8 percent for people who move to an HMO, which is based on other research indicating that HMO costs are between 8 percent and 12 percent lower than in fee-for-service models such as preferred provider organizations (PPO).<sup>19</sup>

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<sup>18</sup> On average, a one percent increase in the price of an insurance product causes about 2.5 percent of members to shift to lower cost products. No savings are calculated for people currently in HMOs. Source: Stombom, B., Buchmueller, T., Feldstein, P. "Switching Costs, Price Sensitivity and Health Plan Choice," *Journal of Health Economics* 21 (2002) 89-116.

<sup>19</sup> Stapleton, D., "New Evidence on Savings from Network Models of Managed Care," (report to the Healthcare Leadership Council), The Lewin Group, Washington, DC, May 1994.

We estimate that enrollment in HMOs would increase from about 30 percent of the privately insured population under current law to about 43 percent under the McCain plan. We assumed that savings would be about 8 percent for people who move to such a plan, as explained above.

Several studies have shown that increases in managed care enrollment result in a sustained, long-run reduction in the rate of growth in health spending throughout the community. Some of these studies include:

- Using California hospital cost data, Robinson has shown that the growth in hospital costs was slowed after state law changed to permit selective contracting in 1982.<sup>20</sup> Robinson estimated that a ten percentage point increase in HMO enrollment was associated with a 1.5 percentage point reduction in the annual rate of growth in hospital spending.<sup>21</sup>
- Welch showed that the growth in Medicare costs is reduced as the Medicare HMO market share increases and that savings grow over time.<sup>22</sup> Welch's study found that a 10 percentage point increase in managed care enrollment was associated with a 1.0 percentage point reduction in the annual rate of growth in Medicare costs.
- The Lewin Group estimated that as enrollment in HMOs in a community increases by 10 percent, the annual rate of growth in hospital spending is reduced by 1.3 percentage points.<sup>23</sup>

Based upon this research, we estimate that the rate of growth in spending for private health insurance would be reduced by about 0.2 percentage points per year. This compares with our assumed growth in per-capita spending of 6.7 percent per year. As shown in *Figure A-12* we estimate that national health spending would decline by about \$161.6 billion over the 2010 through 2019 period.

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<sup>20</sup> Robinson, J.C., "HMO Market Penetration and Hospital Cost Inflation in California," *Journal of the American Medical Association*, 266 (20 November 1991): 2719-23.

<sup>21</sup> Zwanziger and Melnick, "Costs and Price Competition in California Hospitals, 1980-90," *Health Affairs*, Vol. 13, No 4, Fall 1994.

<sup>22</sup> Welch, W.P., "HMO Market Share and its Effect on Local Medicare Costs," *HMOs and the Elderly*, Health Administration Press, Ann Arbor Michigan, 1994.

<sup>23</sup> "Managed Care Savings for Employers and Households: 1990 through 2000," Report to the American Association of Health Plans, The Lewin Group, May 1997.



Figure A-12  
Reduction in National Health Spending Due to Changes in Tax Policy under the McCain Plan  
(billions)

Year	Federal Spending for Health	State and Local Government Spending for Health	Private Employer Health Spending	Family Health Spending	National Health Spending
2010	\$0.2	\$0.9	\$3.8	\$2.9	\$7.8
2011	\$0.2	\$1.1	\$4.4	\$3.3	\$9.0
2012	\$0.3	\$1.3	\$5.4	\$4.1	\$11.1
2013	\$0.3	\$1.6	\$6.4	\$4.8	\$13.1
2014	\$0.4	\$1.8	\$7.3	\$5.5	\$15.0
2015	\$0.4	\$2.0	\$8.3	\$6.3	\$17.0
2016	\$0.5	\$2.2	\$9.2	\$7.0	\$18.9
2017	\$0.5	\$2.5	\$10.2	\$7.7	\$21.0
2018	\$0.6	\$2.7	\$11.3	\$8.5	\$23.1
2019	\$0.7	\$3.0	\$12.4	\$9.4	\$25.4
2010-2014	\$1.5	\$6.6	\$27.4	\$20.7	\$56.1
2010-2019	\$4.2	\$19.1	\$78.8	\$59.5	\$161.6

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

## 2. Savings from Elimination of State Mandated Benefits

Most states require that health plans cover a list of mandatory benefits such as mental health, substance abuse, chiropractic care, and other services. Some states such as Minnesota and Connecticut require substantially more services to be covered than others. In some instances, states require that if a specified service is covered, it must meet a set of standards specified in statute.

It has been estimated that in some states, mandatory benefits comprise over 40 percent of covered services. However, a study by the Government Accountability Office (GAO) found the actuarial cost of mandated benefits to be between 5.4 percent and 22.0 of benefit costs.<sup>24</sup> Even this estimate is believed to overstate the impact of mandatory benefits, because many of the benefits that are required typically would be included in most policies, regardless of the mandate.

Permitting the sale of insurance across state lines would provide individual consumers and small employers a means of obtaining insurance that is free of most of the benefits mandates found in most states. As discussed above, we assume that this has the effect of reducing premiums in the individual and employer insurance markets by 5.0 percent overall. It would

<sup>24</sup> General Accounting Office, (1996, August). "Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance," (GAO/HEHS-96-161). Washington, DC.

have no impact on the cost of coverage in self-funded plans, which are exempt from state mandated benefits.

We estimate that this would reduce premiums by about \$7.9 billion if fully implemented in 2010. This would result in reduced premiums for fully insured health plans in both the small group and individual insurance markets. Savings would accrue to all of those paying for health insurance coverage including employers, workers, and individuals purchasing coverage in the non-group market. Savings would accrue for fully insured plans offered by both private and government employers.

However, not all of these savings will translate into reductions in national health spending. This is because some of those covered under these plans will consume some portion of these services anyway but would have paid for them out-of-pocket. We assume that one-third of this spending would continue as out-of-pocket health spending. We assume that the rest would be savings in national health spending. Total savings over the 2010 through 2019 period would be \$71.7 billion (*Figure A-13*).

**Figure A-13**  
**Reduction in National Health Spending due to Elimination of Mandatory Benefits**  
**under the McCain plan**  
**(billions)**

Year	Change in Premiums and Out-of-pocket Spending			Change in Health Spending by Payer Group			
	Reduction in Health Insurance Premiums	Increased Out-of-pocket spending	Reduction in National Health Spending	Federal Spending for Health	State and Local Government Spending for Health	Private Employer Health Spending	Family Health Spending
2010	-\$7.9	\$2.6	-\$5.3	-\$0.3	-\$1.4	-\$5.9	\$2.2
2011	-\$8.4	\$2.8	-\$5.6	-\$0.3	-\$1.5	-\$6.2	\$2.4
2012	-\$9.0	\$3.0	-\$6.0	-\$0.3	-\$1.7	-\$6.6	\$2.6
2013	-\$9.6	\$3.2	-\$6.4	-\$0.3	-\$1.8	-\$7.1	\$2.8
2014	-\$10.2	\$3.4	-\$6.8	-\$0.3	-\$1.8	-\$7.5	\$2.8
2015	-\$10.9	\$3.6	-\$7.3	-\$0.5	-\$2.0	-\$8.0	\$3.1
2016	-\$11.7	\$3.9	-\$7.8	-\$0.5	-\$2.1	-\$8.6	\$3.3
2017	-\$12.4	\$4.1	-\$8.3	-\$0.5	-\$2.3	-\$9.2	\$3.6
2018	-\$13.3	\$4.5	-\$8.8	-\$0.5	-\$2.4	-\$9.8	\$3.8
2019	-\$14.2	\$4.8	-\$9.4	-\$0.5	-\$2.6	-\$10.4	\$4.0
2010-2014	-\$45.2	\$15.1	-\$30.1	-\$1.5	-\$8.1	-\$33.2	\$12.7
2010-2019	-\$107.6	\$35.9	-\$71.7	-\$3.8	-\$19.4	-\$78.9	\$30.3

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

### 3. Prescription Drug Re-importation

The CBO estimates that prescription drug prices are 35 percent to 55 percent lower in other countries than in the US for the same drugs.<sup>25</sup> Prices are lower in other countries, partly because some countries place limits on the prices that can be charged for individual drugs. The main reason for price disparities is that drug companies are free to set prices at lower levels in markets less willing to pay US-level prices so as to maximize sales and profitability in any given market area. This is particularly true for drugs protected by patents that effectively eliminate price competition in cases where there is no therapeutic alternative.

This has led to plans to permit re-importation of drugs acquired in these countries for resale and use in the US. The Medicare Modernization Act of 2003 (MMA), permits the re-importation of drugs from Canada, contingent upon the HHS Secretary's certification of the drug's safety. However, to date, no such certifications have been provided. The McCain plan would permit re-importation of drugs from other countries, subject to safety constraints.

The CBO estimated that a similar piece of legislation passed by the US House of Representatives in July 2003 (HR 2427) would have reduced drug prices in the US by about one percent.<sup>26</sup> There are several reasons why these savings would be small, including:

- Drug companies could adopt contract restrictions with foreign wholesalers prohibiting resale for export.
- Drug manufacturers could differentiate products distributed overseas by size, shape, or color, all of which is subject to FDA regulations, thereby preventing distribution in the US as approved products.
- Foreign regulators could limit or prohibit export to avoid shortages in their own countries.

Based upon the CBO estimate, we assume savings to be one percent for both public and private payers. Our estimates of drug re-importation savings are presented in *Figure A-14* for Medicare and private payers.

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<sup>25</sup> Baker C., "Would Prescription Drug Re-importation Reduce U.S. Drug Spending," *Almanac of Policy Issues*, April 24, 2004, Congressional Budget Office.

<sup>26</sup> Congressional Budget Office, H.R. 2427: The Pharmaceutical Market Access Act of 2003, CBO Cost Estimate (November 2003).

Figure A-14  
Savings from Allowing Re-importation of Prescriptions Drugs: 2010 - 2019  
(billions)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
Medicare											
Drug Re-importation	\$0.7	\$0.7	\$0.8	\$0.9	\$1.0	\$1.1	\$1.2	\$1.2	\$1.3	\$1.4	\$10.3
Private Insurance											
Drug Re-importation	\$2.0	\$2.2	\$2.4	\$2.7	\$3.0	\$3.3	\$3.6	\$4.0	\$4.3	\$4.8	\$32.3
Total Medicare and Private											
Total	\$2.7	\$2.9	\$3.2	\$3.6	\$4.0	\$4.4	\$4.8	\$5.2	\$5.6	\$6.2	\$42.6

Source: The Lewin Group estimates.

#### 4. Medical Malpractice Reform

The McCain plan attempts to reduce medical liability costs by preventing claims that lack merit. Specifically, the McCain plan would eliminate suits directed at physicians who follow clinical guidelines and adhere to safety protocols.

The impact of limiting “frivolous” cases (and the subsequent threat of limiting the practice of plaintiffs’ attorneys) is difficult to determine, because of the lack of a clear definition of what constitutes an improper claim. The percentage of claims without merit ultimately may be quite low, because of the already low number of adverse events that actually go to trial. A 1991 study estimated that only 1.5 percent of all significant adverse medical events led to claims being filed.<sup>27</sup>

While several states have taken a variety of steps to eliminate non-meritorious claims, McCain’s specific proposal has not been implemented at the state level. However, we can form a basis for estimating its impacts based upon the experiences of states that have attempted to eliminate non-meritorious claims.

Seventeen states have implemented certificate of merit requirements.<sup>28</sup> These provisions require the plaintiff to provide a certification that the case has been reviewed by an expert and that the expert has concluded there is some basis for the claim. Empirical information on the impact of these provisions is scarce. A state-level certificate of merit study conducted in

<sup>27</sup> Localio A.R., et al. “Relation Between Malpractice Claims and Adverse Events Due to Negligence,” *NEJM* 1991; 325(4): 245-51.

<sup>28</sup> Struve, C., *Experience in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*. 2003.

Maryland indicated that significantly fewer claims were dismissed voluntarily by the plaintiff in the post-reform period as compared with the pre-reform period.<sup>29</sup>

In Utah, the implementation of pre-litigation review of cases was associated with a 40 percent reduction in cases proceeding to trial.<sup>30</sup> In New Mexico, pre-litigation reviews from 1976 to 1996 found that 75 percent of cases were without merit. However, these data do not provide information on how these provisions affect awards and other costs.

Browne and Puelz estimated the impact of a combination of provisions, including any combination of frivolous suits or defenses, modified rules on pre-judgment interest or structured settlements. The study showed that these provisions reduced noneconomic damages by 4.8 percent and economic damages by 5.9 percent.<sup>31</sup>

Based upon these results, we assume that the McCain provisions pertaining to arbitration and elimination of non-meritorious claims would reduce medical malpractice costs by 5 percent in the states that already do not have certificate of merit requirements. Total savings would be about \$12.2 billion over the 2010 through 2019 period (*Figure A-15*). Based upon the findings of an analysis prepared by the General Accountability Office, we assume that most of the savings would go to privately insured people.

**Figure A-15**  
**Savings from the McCain Medical Malpractice Reform Plans: 2010 - 2019**  
**(billions)**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
Federal Public Programs	\$0.0	\$0.1	\$0.2	\$0.3	\$0.3	\$0.3	\$0.3	\$0.4	\$0.4	\$0.4	\$2.7
State Public Programs	\$0.0	\$0.0	\$0.0	\$0.1	\$0.1	\$0.2	\$0.2	\$0.2	\$0.2	\$0.3	\$1.3
Private Insurance	\$0.2	\$0.4	\$0.6	\$0.8	\$0.9	\$1.0	\$1.0	\$1.1	\$1.1	\$1.1	\$8.2
<b>Total</b>	<b>\$0.2</b>	<b>\$0.5</b>	<b>\$0.8</b>	<b>\$1.2</b>	<b>\$1.3</b>	<b>\$1.5</b>	<b>\$1.5</b>	<b>\$1.7</b>	<b>\$1.7</b>	<b>\$1.8</b>	<b>\$12.2</b>

Source: The Lewin Group estimates.

### *5. Care for the Chronically III*

The McCain plan describes three initiatives intended to improve care for the chronically ill population. The language used to describe these initiatives in the McCain literature is as follows:

<sup>29</sup> Morlock and Malitz, "Short-term Effects of Tort and Administrative Reforms on Claiming Behavior of Privately Insured, Medicare, Medicaid, and Uninsured Patients," Washington, D.C. U.S. Congress, Office of Technology Assessment, 1993.

<sup>30</sup> Utah Legislative Auditor General, "1993 Audit: Medical Malpractice Pre-litigation Panels."

<sup>31</sup> Ibid.

**“Prevention and chronic disease management:** Would promote coverage of preventive services. Would make patients the center of care and give them a larger role in both prevention and care, putting more decisions and responsibility in their hands. Promote care alternatives such as walk-in clinics in retail outlets. Would use public health initiatives to encourage individuals to prevent chronic disease, receive appropriate tests for early detection, and follow treatment guidelines after disease develops. Parents would be responsible for ensuring children are taught about health, nutrition, and exercise. Children should be provided healthy dietary choices in schools. Public health leadership, including the next President, must promote lower rates of obesity. In Medicaid, would promote care management for the disabled and elderly.”

**“Comparative effectiveness/quality improvement:** Federally sponsored research should focus on the care and cure of chronic disease and the treatment of patients with multiple chronic conditions. Facilitate the development of national standards for measuring and recording treatments and outcomes. Government programs such as Medicare and Medicaid should lead the way in health care reforms that improve quality and lower costs.”

**“Pay-for-Performance:** Pay only for quality care that is the right care: care intended to improve a patient’s health. Medicare and Medicaid should be leaders on changing the way providers are paid to focus their attention more on chronic disease and managing treatment. Reform the payment systems in Medicare to compensate providers for diagnosis, prevention, and care coordination. Medicare could pay a single bill for high-quality coordinated care in which providers collaborate to produce the best health outcome for a patient. Medicare should not pay for preventable medical errors or mismanagement.”

These initiatives are not specified to the point where it is possible to estimate their impacts. For example, the campaign pledges to “promote” practices that could reduce costs. But the plan does not include information on the amount of federal funds that would be devoted to these initiatives and does not require use of these models in federal programs.

However, the plan does indicate that it would change provider payment incentives in government programs to emphasize chronic care management and coordination. We assume that these payment incentives would be changed for all providers. This implies that all beneficiaries would be covered under this care coordination provision.

#### *a. Improved Coordination of Care*

For illustrative purposes, we assume that the combined impact of these changes would be to improve coordination of care for people being treated for multiple health conditions. The plan would change provider incentives under Medicare by paying primary care providers to provide disease management and care coordination services. Federally sponsored research would be redirected to focus on treatment for people with chronic disease. Pay-for-performance methods could also be developed to reward providers for keeping patients healthy.

Under this model, patients would select a primary care provider. The designated provider, usually a primary care physician, would then be responsible for coordinating the care provided to the patient by all health care providers. In fact, over half of people with serious chronic

conditions are receiving care from three or more physicians.<sup>32</sup> This can result in duplicate tests, conflicting medical advice, and prescriptions for contraindicated medications.

The McCain plan omits important details on how the program would be implemented. We assume that primary physicians are paid a monthly fee of \$4.00 per patient with a chronic condition. This is comparable to that paid under Medicaid primary care case management programs for TANF beneficiaries, yet less than the typical management fees paid for Medicaid patients with chronic conditions. We also assume that bonuses would be paid for physicians who produce good health outcomes. We assume that this is done by lowering provider payments in other parts of the program so that there is no net increase in the Medicare program spending.

### *b. Program Impact Estimates*

Based upon the estimates provided by Anderson (2004), we assumed that 50 percent of Medicare spending is attributed to Medicare beneficiaries with multiple chronic conditions that would be eligible for the care coordination program.<sup>33</sup> We assume that this group accounts for about 75 percent of Medicare spending. We assume that 75 percent of all Medicare recipients with chronic conditions are enrolled in the program, reflecting access constraints that may exist in the system. Based upon historical data on the growth in enrollment in the Medicare HMO program, now called Medicare Advantage, we assume that enrollment would phase-in over the first four years of the program.<sup>34</sup>

We estimated the savings from this approach based upon the Momany et al. estimates of savings when applied in Medicaid. Momany projected net savings that increased from 1.5 percent in 1991 to 9.8 percent in 1998.<sup>35</sup> The average annual savings over the period of their estimates was 3.8 percent. To incorporate a \$4 rather than a \$2 payment rate to physicians in the Momany study, we reduced the net savings by 8 percent each year, resulting in an average savings estimate of 3.5 percent. However, because patients are permitted to access specialists without referral without penalty, we assume that the effectiveness of the program is reduced by about one-third to 2.5 percent.

Using these assumptions, we estimate savings to Medicare of \$144.4 billion over the 2010 through 2019 period (*Figure A-16*).

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<sup>32</sup> Gerald Anderson et al., "Chronic Conditions: Making the Case For Ongoing Care," 2004, Partnership for Solutions, (Johns Hopkins and Robert Wood Johnson Foundation (RWJF)).

<sup>33</sup> Ibid.

<sup>34</sup> CMS managed care enrollment reports at:  
[http://www.cms.hhs.gov/HealthPlanRepFileData/02\\_SC.asp#TopOfPage](http://www.cms.hhs.gov/HealthPlanRepFileData/02_SC.asp#TopOfPage).

<sup>35</sup> 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).



**Figure A-16**  
**Projected Savings in Medicare Expenditures under McCain Coordinated Care Provisions**  
**(billions)**

Year	Projected Medicare Expenditures <sup>a/</sup>	Medicare Spending for Group Enrolled in Medical Home	Percent Savings From Care Coordination	Medicare Program Savings
2010	\$545.60	\$41.0	0.8%	\$0.3
2011	\$602.00	\$135.5	1.5%	\$2.0
2012	\$610.30	\$274.7	2.2%	\$6.0
2013	\$680.20	\$571.4	2.5%	\$14.3
2014	\$739.70	\$621.3	2.5%	\$15.5
2015	\$805.80	\$676.8	2.5%	\$16.9
2016	\$907.30	\$762.2	2.5%	\$19.1
2017	\$1,024.80	\$860.9	2.5%	\$21.5
2018	\$1,111.90	\$934.1	2.5%	\$23.4
2019	\$1,206.40	\$1,013.4	2.5%	\$25.3
<b>2010-2014</b>	<b>\$3,177.80</b>	<b>\$1,643.7</b>	<b>N/A</b>	<b>\$38.2</b>
<b>2010-2019</b>	<b>\$8,234.00</b>	<b>\$5,891.0</b>	<b>N/A</b>	<b>\$144.4</b>

a/Medicare expenditure projections were taken from the Fact Sheet for CBO's March 2008 Baseline: Medicare.

Source: The Lewin Group estimates.

## 6. Health Information Technology (HIT)

The McCain campaign states that they would “Promote rapid deployment of modern information systems. Use telemedicine to connect community health clinics in areas where services and providers are limited.” While the McCain campaign has indicated that federal funds would be provided to promote HIT, they are not able to say how much.

HIT systems center around computerized systems for recording patient medical histories, test results, and prescriptions called an electronic medical records (EMR).<sup>36</sup> The EMR would feature

<sup>36</sup> Brailer, in his discussion of computer-based patient records focuses on the lack of commonly accepted and discrete definitions and terminology that have resulted in some confusion and slowed the progress of technology adoption. The terms he listed to give perspective on the problem are : automated medical record (AMR), clinical data repository (CDR), computer-based patient record (CPR), computer-based patient record system (CPRS), computer-based patient record-type system (CPRS), computerized medical record (CMR), computerized patient record (CPR), electronic health record (EHR), electronic medical record (EMR), lifetime data repository (LDR), virtual health record (VHR) and virtual patient record (VPR). This list does not include the various terminologies for computer physician order entry or electronic prescribing programs.



standardized terminology and reporting formats that eliminate the dangers arising from illegible handwriting and missing patient data.<sup>37</sup>

The literature provides evidence of the potential cost impacts of such systems. Perhaps the best known of these articles is a study by Federico Girosi et al. of RAND, Inc. that estimates the potential savings from HIT to be about \$80.9 billion per year (in 2005 dollars) if fully implemented throughout the health care system.<sup>38</sup> *Figure A-17* presents Girosi's estimates of potential savings from HIT by functional area including transcription, chart pulls, laboratory tests, and improvements in efficiency for limited nursing staff.

**Figure A-17**  
**Girosi Estimates of HIT-Enabled Savings over 15-year Adoption Period**  
**(billions)**

Source of Savings	Potential Savings	Savings in 5 <sup>th</sup> Year of Adoption Period	Savings in 10 <sup>th</sup> Year of Adoption Period	Savings in 15 <sup>th</sup> Year of Adoption Period
<b>Outpatient Savings</b>				
Transcription	\$1.9	\$0.4	\$1.2	\$1.7
Chart Pulls	\$1.7	\$0.4	\$1.1	\$1.5
Laboratory Tests	\$2.2	\$0.5	\$1.5	\$2.0
Drug Utilization	\$12.9	\$3.0	\$8.6	\$11.8
Radiology	\$3.6	\$0.8	\$2.4	\$3.3
Total	\$22.3	\$5.2	\$14.8	\$20.4
<b>Inpatient Savings</b>				
Nurse Shortage	\$12.7	\$3.4	\$10.0	\$13.7
Laboratory Tests	\$3.0	\$0.8	\$2.2	\$2.8
Drug Utilization	\$3.7	\$1.0	\$2.8	\$3.5
Length of Stay	\$36.7	\$10.1	\$27.6	\$34.7
Medical Records	\$2.5	\$0.7	\$1.9	\$2.4
Total	\$58.6	\$16.1	\$44.5	\$57.1
<b>Combined Total</b>				
Total	\$80.9	\$21.3	\$59.2	\$77.4

Source: Federico Girosi et al., *Extrapolating Evidence of Health Information Technology Savings and Costs*, Santa Monica, California: RAND Corporation, MG-410-HLTH, 2005.

<sup>37</sup> Advanced HIT systems also could facilitate the compilation for outcomes analyses and health quality measures that provide continual feedback to providers on the effectiveness of the care provided.

<sup>38</sup> Federico Girosi et al., *Extrapolating Evidence of Health Information Technology Savings and Costs*, Santa Monica, California: RAND Corporation, MG-410-HLTH, 2005.

The authors assume that this technology would be adopted by the industry over a period of 15 years. This is based on studies of the amount of time it has taken for other information technologies to be adopted. These data indicate that adoption tends to level off at about 90 percent after the 15<sup>th</sup> year.

They estimate that savings would reach \$21.8 billion in the fifth year of the adoption period, which we assume will be in 2010. Savings rise to \$59.2 billion in the tenth year and \$77.4 billion by the fifteenth year (*Figure A-17*).

It is important to understand that the authors are projecting that most of these savings will materialize over the next 15 years regardless of any change in public policy – these savings are already reflected in the current law “baseline” estimates of health spending over the next 15 years. Thus, the government may only accelerate the adoption of HIT.

It is also important to recognize that the Girosi estimates are of potential savings rather than realizable savings. They used in their work only those studies that showed savings while excluding those that did not show savings. This was intended to show potential savings if the use of these systems could be optimized by all potential users. However, because the effectiveness of any new technology will be uneven across users, the savings that we can expect to realize from these systems is less than the \$80.9 billion in potential savings estimated by Girosi.

Other studies are available on the cost impacts of Computerized Physician Order Entry (CPOE) and Clinical Decision Support (CDS) systems, but there is little evidence of savings from the detailed EMR itself. Savings from CPOE have been documented in both inpatient and ambulatory care settings. There is also growing evidence that CPOE and other elements of these technology advances would help avoid medical errors and reduce unnecessary duplication of tests in hospitals resulting in reduced health spending. Studies indicate savings of between \$5.0 million and \$26.0 million for individual hospitals adopting elements of these HIT systems.<sup>39</sup>

A study by Bates found that CPOE for tests and prescriptions reduced non-intercepted serious medication errors by 55.0 percent, with a reduction in hospital charges of about 12.7 percent. Another study showed that a CPOE program assisting with antibiotic management resulted in a fivefold decrease in the frequency of excess drug dosages and a tenfold decrease in antibiotic-susceptibility mismatches resulting in reduced health care costs.

Savings also are likely to result from automated systems in ambulatory care settings, such as physician offices. A study of 59 physician practices documented savings and increased revenues of about \$1.0 million compared with the prior year.<sup>40</sup> Savings in physician offices resulted from reduced need for transcription services, decreased labor and supply costs for chart maintenance and creation, and decreased physical space requirements due to the use of a

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<sup>39</sup> Bates, D., Teich, J., Lee, J., et al. (1999). The Impact of Computerized Physician Order Entry on Medication Error Prevention. *Journal of the American Medical Informatics Association*, 6, 313-21.

<sup>40</sup> Barlow, S., Johnson, J., and Steck, J. (2004). The Economic Effect of Implementing an EMR in an Outpatient Setting. *Journal of Healthcare Information Management*, 18(1), 46-51.

paperless record. For example, it has been estimated that each physician request for a patient's medical record, called a "chart pull," can cost between \$8 and \$9 in labor and other costs. This study showed that the number of chart pulls requested declined by about 40 percent.<sup>41</sup>

While accelerated adoption of HIT could result in savings, we are unable to estimate savings for the McCain proposal due to a lack of specificity on what the program would do and how it would be funded.

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<sup>41</sup> Johnston, D. (2003). *The Value of Computerized Provider Order Entry in Ambulatory Settings*. Boston: Center for Information Technology Leadership. The study estimates that another \$27 billion could be saved through increased compliance with drug formularies (e.g., increased use of generic drugs), although these potential savings have yet to be demonstrated.







## Appendix B: Analysis of Senator Obama's Health Proposals by Major Provision

Senator Obama's plan would expand health insurance coverage through public programs and private health insurance. The program requires that medium to large employers either offer insurance or pay a tax equal to a percentage of worker wages and salaries to the government. It encourages employers to offer coverage by providing a new tax credit for small employers offering coverage and a reinsurance program for all employers that would cover a portion of costs for individuals with "catastrophic" health care costs.<sup>1</sup> The program also requires parents to cover their children; however, the campaign has not specified an enforcement mechanism.

The Senator's plan expands Medicaid to cover very low-income adults. In addition, it establishes a program to provide subsidies for the purchase of private insurance for people without employer coverage whose income is too high to qualify for Medicaid, but too low to afford private health insurance on their own.

To ensure that coverage is available, the Obama proposal would require all insurers to take all applicants regardless of health status, and prohibit insurers from setting premiums on the basis of health status. It establishes a "national exchange" that would provide consumers with a selection of health insurance options and explain differences across plans, including the cost of services. In addition, a new public plan is created that would be available through the exchange.

The Obama plan includes several initiatives designed to improve the quality of health care while helping to control costs. It establishes an institute to guide reviews and research on the comparative effectiveness of alternative diagnostic and therapeutic interventions whose findings would be used to provide accurate and objective information in support of decisions made by doctors and patients. It would also fund the adoption of health information technology (HIT) that reduces costs and can improve the quality of care for consumers. To reduce costs for the chronically ill, it emphasizes the medical home model and disease management. The plan would also establish pay-for-performance programs that reward physicians for preventing illness and providing high-quality health care.

*Figure B-1* shows our estimates of transitions in coverage occurring under the Obama plan. In this section we present our analysis of the impact of the Obama health care proposal on coverage and costs in the health care system. Our analysis is presented in the following sections:

- Provisions Affecting Employers;
- Medicaid Expansions;
- Premium Subsidies and the National Exchange;
- Prescription Drug Provisions;

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<sup>1</sup> The Obama plan has not yet established a threshold for "catastrophic" costs.

- Elimination of Medicare Advantage Plan Overpayments;
- Comparative Effectiveness Research;
- Promotion of Health Information Technology (HIT);
- Coordination and Integration of Care (medical homes); and
- Incentives for Quality (Pay-for-Performance or P4P).



Figure B-1  
Transitions in Coverage under the Obama Plan in 2010 (thousands)

		Coverage Under the Obama Plan									
		Coverage in National Public Plan		Private Coverage (in and out of Exchange)					Medicare & Medicaid Dual Eligibles	Medicaid and SCHIP	
Coverage Under Current Law		Employer	Individual	Employer	Individual	Retiree	TRICARE	Medicare			Uninsured
Employer Workers and Dependents	153,801	12,943	1,487	131,296	938	-	-	-	-	5,654	1,483
Private Non-Employer	14,252	777	7,828	1,246	3,449	-	-	-	-	790	162
Employer Retiree	3,647	-	-	-	-	3,647	-	-	-	-	-
TRICARE	6,044	-	-	-	-	-	6,044	-	-	-	-
Medicare	32,179	-	-	-	-	-	-	32,179	-	-	-
Medicare & Medicaid Dual Eligibles	6,750	-	-	-	-	-	-	-	6,750	-	-
Medicaid and SCHIP	41,466	1,241	-	1,919	-	-	-	-	-	38,306	-
Uninsured	48,918	3,592	3,784	5,423	2,099	-	-	-	-	13,399	20,621
<b>Total</b>	<b>307,057</b>	<b>18,553</b>	<b>13,099</b>	<b>139,884</b>	<b>6,486</b>	<b>3,647</b>	<b>6,044</b>	<b>32,179</b>	<b>6,750</b>	<b>58,149</b>	<b>22,266</b>

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

## A. Provisions Affecting Employers

The Obama plan includes several provisions that would affect the cost of insurance to employers. These include the following:

- **Employer Contribution Requirement:** Medium to large (25 or more workers) employers who do not make a “meaningful” contribution to employer coverage would be required to pay a percentage of payroll towards the cost of the coverage expansions.
- **Small Business Tax Credit:** The plan provides for a tax credit to small employers with low- and moderate-income workers for up to 50 percent of the amount of the employer contribution for insurance.
- **Employer Reinsurance Program:** The plan would provide reinsurance to employers to cover the cost of patients experiencing catastrophic health care costs.
- **Changes in Insurance Markets:** The plan permits employers and individuals to purchase coverage through a purchasing pool modeled on the Federal Employees Health Benefits Program (FEHBP).
- **Other Savings:** The Obama plan includes several provisions designed to reduce health care costs that will help reduce premiums and increase employer coverage.

All of these elements will work together to reshape the cost of coverage to employers. For example, the elimination of health status rating would increase premiums for some firms while decreasing premiums for others. The tax credit and the reinsurance program would also reduce the cost of insurance to most employers, which could lead to an increase in coverage. Other provisions of the Obama plan will also reduce health spending in general which would further reduce premiums. On the other hand, the expanded availability of Medicaid and subsidized non-group coverage may cause some employers to discontinue coverage so that workers can obtain coverage through these subsidized coverage programs.

Our approach is to simulate the cost of coverage for each employer in the Health Benefits Simulation Model employer database under the Obama plan. This includes the effects of changes in insurer rating practices, small business tax credits, the reinsurance plan and other factors affecting the cost of coverage. We then simulate how the employers respond to these changes in costs. These changes are likely to result in some non-insuring employers deciding to offer coverage while causing some other employers to discontinue the coverage they now offer. The methods used to simulate the impact of the Obama plan on employer coverage are summarized below.

### 1. Employer Contribution Requirement

The Obama plan requires medium to large employers to either provide a “meaningful contribution” for coverage for their workers or pay a payroll tax that will be used to pay for coverage expansions under the Obama plan. However, the plan does not define what qualifies as a “medium to large” firm or specify the details of the employer contribution.

To estimate the coverage and cost impacts of this requirement, we needed to make certain assumptions regarding the details of the proposal. These include:

- **Meaningful coverage:** We assume that to be exempt from the payroll tax, the employer must provide coverage at least as comprehensive as the FEHBP benefit, which we assume to be the same as the Blue Cross/Blue Shield standard option. We have estimated that the actuarial value of this benefits package is at about the 60th percentile among employer plans.
- **Meaningful contribution:** We assume that the employer is required to pay 66 percent of the premium, which is the 25<sup>th</sup> percentile for employer contribution among employer plans in the US.
- **Payroll tax:** We assume a payroll tax rate of 6.0 percent for workers in firms that do not provide the minimum level of coverage.
- **Definition of small firm:** We assume that firms with fewer than 25 employees are exempt from the requirement.

As discussed above, our approach is to estimate the cost of coverage for a sample of employers including those who do and do not offer coverage. As discussed in Appendix A, our data is based upon the 2006 Kaiser Family Foundation (KFF) survey of employers which we supplement with data from the 1997 employer survey sponsored by the Robert Wood Johnson Foundation (RWJF). We do this using the rating rules that apply under current law and again using the rules adopted in the Obama plan. These premium estimates reflect the impact of the reinsurance program and other cost savings features of the Obama plan.

In addition, we estimate what the cost of insurance would be for each employer's workforce if their workers did not have employer coverage. This reflects the availability of Medicaid to low-income workers, the cost of non-group premiums less subsidies provided under the Obama plan and the employer payroll tax the employer would be required to pay if they do not offer insurance.

Using these data we estimate which employers will take coverage and which will not. We use the following rules to make these choices:

- **Firms that currently offer insurance:** We assume that these firms will continue to provide coverage as long as it is more beneficial to their workers. We first compute the cost of coverage for each employer's workforce if the employer continues to provide insurance. We then calculate the cost of coverage to each employer's workforce if they purchase coverage in the non-group market with the various subsidies provided under the proposal, plus the amount of the payroll tax the employer would be required to pay. Employers are assumed to cash out their plans (i.e., convert benefits to wages and discontinue their plan) only if the cost of non-group coverage (or Medicaid) to their workforce is lower than the cost of providing coverage through employer insurance.
- **Firms that currently do not offer insurance:** Non-insuring firms are assumed to offer coverage if the cost of providing insurance is less than what it would cost their workers to purchase coverage in the non-group market or enroll in Medicaid, plus the amount of the payroll tax.

Our approach allows for the effect of several factors on the cost of employer coverage, including the fact that group insurance is typically less costly to administer than non-group coverage. It

reflects the various subsidies provided to employers under the proposal including the tax credit and the reinsurance. It also reflects the availability of Medicaid and premium subsidies for non-group coverage and the effect this has on the relative cost advantages of employer coverage.

## *2. Reinsurance Program*

Under this program, the federal government would provide a federally financed reinsurance benefit to all employer plans to help cover costs for plan members experiencing catastrophic costs. In today's system, insurers and self-funded employers often purchase reinsurance to protect themselves against catastrophic losses. The health plan typically pays a premium to the reinsurer who agrees to cover catastrophic costs. For example, a typical reinsurer might cover 75 percent of costs for individual plan members over \$50,000, up to a maximum of \$1.0 million per case.

The Obama reinsurance plan differs from traditional reinsurance in that employers are not required to pay a premium. The full cost of covering catastrophic losses would be paid by the federal government. The Obama plan does not specify the details of the formula that would be used to cover catastrophic losses. However, a document from health advisors to the campaign indicates that the program is expected to reduce employer premiums by 4 percent.

For illustrative purposes, we specified a reinsurance model that would reduce overall employer costs by 4 percent. For 2010, the program would cover 75 percent of losses in excess of \$140,000 for plan members. We estimate that this would cost the federal government about \$31.0 billion in 2010, which is roughly equal to 4 percent of employer health benefits costs.

The savings to employers would vary depending upon the health status and costs for group participants. Under current health insurance rating practices – generally regulated by states – group premiums typically tend to reflect the age composition and health status of the group they are covering. Consequently the percentage savings for individual groups tend to be highest among groups with higher health costs.

*Figure B-2* presents estimated savings for groups by the amount of the premiums under current law. These data show higher percentage savings than plans with relatively lower premium costs.

Figure B-2:  
Estimated Effect of the Obama Reinsurance Program on Employer Premiums: 2010 <sup>a/</sup>

Insuring Employers by Average PMPM Costs for Group <sup>b/</sup>	Workers and Dependents (millions)		Benefits and Administrative Costs		Costs over \$140,000		Percent Reduction in Benefits and Admin. Costs Under the Reinsurance Plan
	Number	Percent	Amount (billions)	Percent	Amount (billions)	Percent	
Less than \$242	37.4	23.6%	\$103.1	13.5%	\$0.6	1.5%	0.4%
\$242 to \$330	39.5	24.9%	\$163.9	21.5%	\$2.7	6.7%	1.2%
\$331 to \$406	40.7	25.7%	\$196.0	25.7%	\$9.2	22.8%	3.5%
\$407 or more	40.8	25.8%	\$298.7	39.2%	\$27.9	69.1%	7.0%
<b>Total</b>	<b>158.4</b>	<b>100.0%</b>	<b>\$761.8</b>	<b>100.0%</b>	<b>\$40.4</b>	<b>100.0%</b>	<b>4.0%</b>

a/ Includes all insured workers and dependents.

b/ Excludes insurer administration.

Source: The Lewin Group estimates.

The premium rebate program would reduce the cost of coverage for participating employer groups, which is expected to increase the number of employers offering coverage.

### 3. Small Business Tax Credit

The Obama plan would provide a tax credit for up to 50 percent of the employer cost of insurance for small employers. The campaign has not provided information on the eligibility requirements for the credit and the formula used to determine the tax credit amounts. However, the campaign has indicated that they intend to ask the Department of the Treasury to define the details of the tax credit such that the federal cost of the program does not exceed \$6.0 billion.

We began our analysis by defining a tax credit that could be provided within the budget of \$6.0 billion. We assumed the credit is available to firms with fewer than 25 workers. We assumed that firms with an average wage level below twice the minimum wage (roughly \$24,000 per year for a full time full year worker) would qualify for the full 50 percent credit for the employer premium contribution. We assumed that the amount of the credit is phased-out for firms with an average payroll between twice the minimum wage and three times the minimum wage. Finally, we assumed that the \$6.0 billion cap is applied to this component of the program only, rather than representing a *net* cost increase after taking into account offsetting federal savings attributable to reductions in Medicaid spending and individual subsidies.

We simulated the increase in coverage based upon estimates of how changes in premiums affect the employer decision to offer coverage. For example, as described in *Appendix A*, the data we used indicates that among firms with fewer than 10 workers, each one percent reduction in premium is associated with an approximate 0.87 percent increase in the number of employers offering coverage.

To keep the cost of the credit to the \$6.0 billion budgeted amount, we had to limit the credit to only employers with 10 or fewer workers. We also found that we had to limit the credit to only firms with an average payroll of less than twice the minimum wage.

Using these eligibility criteria, there are about 3.6 million workers and dependents in small firms eligible for the credit. Of these, about 1.9 million are in firms that are already offering insurance. The credit would also go to 1.7 million workers and dependents in newly insuring firms (*Figure B-3*). Total tax credit payments would be about \$6.0 billion, of which \$3.9 billion would go to firms that already provide insurance. The remaining \$2.1 billion would go to currently non-insuring firms that are induced to offer coverage under the various provisions of the Obama proposal.

**Figure B-3**  
**Impact of the Small Business Tax Credit under the Obama Plan Assuming**  
**Full Implementation in 2010 <sup>a/</sup>**

	All Covered Workers and Dependents in Small Firms (1,000s) <sup>b/</sup>	Covered Workers and Dependents in Small Firms Eligible for Tax Credits (1,000s) <sup>b/</sup>	Total Tax Credit Amount (billions)
<b>Currently Insuring Employers that Continue to Offer Coverage</b>			
Provide Private Coverage	5,268	663	\$1.7
Provide Coverage Through Exchange	7,930	1,259	\$2.2
<b>Total</b>	<b>13,198</b>	<b>1,922</b>	<b>\$3.9</b>
<b>Currently Non-insuring Employers that Offer Coverage Under the Proposal</b>			
Provide Private Coverage	501	65	\$0.1
Provide Coverage Through Exchange	3,396	1,637	\$2.0
<b>Total</b>	<b>3,897</b>	<b>1,702</b>	<b>\$2.1</b>
<b>All Small Employers</b>			
<b>Total</b>	<b>17,095</b>	<b>3,624</b>	<b>\$6.0</b>

a/ Assumes that the tax credit is available to firms with fewer than 10 workers with an average full-time equivalent payroll below 200 percent of the minimum wage.

b/ A small firm is defined to be an employer with fewer than 10 workers.

Source: The Lewin Group estimates.

#### 4. Insurance Market Regulation

The Obama health plan requires insurers to guarantee coverage to all applicants and prohibits them from varying premiums with health status. Under the Health Insurance Portability and Accountability Act (HIPAA), insurers in the employer market are already required to cover any individual who has maintained their coverage under an employer health plan for at least 12 months. However, in all but 11 states, insurers are permitted to vary premiums with health status.

We simulated premiums for employer health coverage using the HBSM employer insurance market model and our database of employers. We estimate premiums for each employer,

including those who do not now offer insurance, under the rating practices currently used in each state and again without the use of health status rating. This resulted in an increase in premiums for some employers while reducing premiums for others.

*Figure B-4* shows our estimates of the number of workers in small firms by the amount of the change in their per-worker premium for single and family coverage. These changes in premiums reflect the elimination of health status rating and the effect of the reinsurance program under the Obama plan. They also reflect savings resulting from enrollment in the national exchange and the national public plan. As discussed below, premiums in the national exchange would be about 5 percent lower for plans participating in the exchange and nearly 25 percent lower in the National Plan. Our simulations of changes in coverage for small firms reflected these changes in premiums.

**Figure B-4**  
**Distribution of Workers in Small Firms by the Amount of the Change in Premium Resulting from Elimination of Health Status Rating and Other Factors under the Obama Plan in 2010**

Change in Monthly Premium	Workers (1,000s)	Percent of Workers	Workers by Health Status			
			Excellent/ Very Good	Good	Fair	Poor
Family Coverage						
Decrease \$200 or more	2,463	32%	32%	33%	33%	51%
Decrease \$100 - \$199	1,127	15%	15%	12%	12%	0%
Decrease \$50 - \$99	653	9%	8%	11%	3%	0%
Decrease \$20 - \$49	482	6%	6%	6%	12%	0%
No Change +/- \$20	859	11%	11%	12%	11%	4%
Increase \$20 - \$49	367	5%	5%	4%	9%	18%
Increase \$50 - \$99	422	6%	6%	5%	7%	3%
Increase \$100 - \$199	700	9%	9%	9%	6%	24%
Increase \$200 or more	533	7%	7%	8%	7%	0%
Single Coverage						
Decrease \$200 or more	563	7%	6%	8%	6%	39%
Decrease \$100 - \$199	1,531	18%	17%	19%	25%	39%
Decrease \$50 - \$99	1,069	12%	12%	12%	22%	0%
Decrease \$20 - \$49	1,120	13%	13%	14%	9%	0%
No Change +/- \$20	1,214	14%	15%	11%	10%	0%
Increase \$20 - \$49	796	9%	9%	8%	10%	0%
Increase \$50 - \$99	913	11%	11%	12%	3%	0%
Increase \$100 - \$199	1,094	13%	13%	12%	12%	22%
Increase \$200 or more	299	3%	3%	4%	2%	0%

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



### *5. Simulating the Impact of Changes in Premiums on Employer Coverage*

The Obama proposal includes several provisions that are likely to affect the cost of insurance to employers. These include:

- The reinsurance program;
- The small employer tax credit;
- Employer group insurance market reforms;
- The availability of lower-cost coverage in the national exchange; and
- Various cost containment initiatives such as comparative effectiveness research and promotion of health information technology.

We simulated the impact of these provisions on employer coverage using our database of employers. We first estimated premiums for each firm in the database with the elimination of health status rating as required in the Obama plan. We then adjusted premiums to reflect the cost effects of the reinsurance, the small group tax credit and other cost savings resulting from the cost containment features of the plan. In addition, we included the impact of the national exchange on benefits costs and administrative expenses as discussed below.

We simulated the change in employer coverage based upon estimates of how changes in premiums affect the employer decision to offer coverage. For example, as described above, the data we used indicates that among firms with fewer than 10 workers, each one percent reduction in premium is associated with an approximate 0.87 percent increase in the number of employers offering coverage. We estimated increases in coverage among most firms because most employers would see at least a small reduction in premiums. However, we did simulate a small reduction in employer coverage among those facing lower premiums due to the elimination of health status rating.

### *6. Combined Effects of Employer Provisions*

We project that in 2010 there will be about 153.8 million people covered under employer health plans as a worker or a dependent. We estimate that the number of people with employer coverage would increase by 4.6 million people under the Obama proposal. However, there would be significant shifts in employer coverage.

For example, we estimate that about 6.5 million workers and dependents would be in firms that discontinue their coverage due to the availability of subsidized coverage through Medicaid or the national exchange. As discussed above, these include employer groups where the cost of insurance for the workforce is actually lower if the group were to obtain coverage under Medicaid or in the non-group market with the subsidies, despite the payroll tax the employer would be required to pay. In addition, we estimate that among firms that continue their coverage, about 3.1 million low-income workers would decline employer coverage to take free coverage under the expanded Medicaid program.



**Figure B-5**  
**Change in Employer Coverage under the Obama Plan in 2010**  
**(thousands)**

	Workers and Dependents	
<b>Current Employer Coverage for Workers and Dependents</b>		<b>153,801</b>
<b>Employers Who Drop Coverage Due to Subsidy Programs</b>		<b>(6,484)</b>
Workers and Dependents Who Become Covered by Medicaid/SCHIP	(2,576)	
Workers and Dependents Who Become Covered Through the Exchange	(1,487)	
Workers and Dependents Who Become Covered by Private Individual Insurance	(938)	
Workers and Dependents Who Become Uninsured	(1,483)	
<b>Workers and Dependents Who Discontinue Employer Coverage to Enroll in Medicaid/SCHIP Expansions</b>		<b>(3,078)</b>
<b>Currently Insuring Employers Who Buy Into the Exchange</b>		<b>N/A</b>
Firms with 2-9 Workers	7,930	
Firms with 10-25 workers	5,439	
<b>Newly Covered Workers and Dependents who Previously Declined Coverage</b>		<b>525</b>
<b>Employers Who Newly Offer Coverage</b>		<b>13,673</b>
Workers and Dependents in Small Firms That Offer Private Coverage	725	
Workers and Dependents in Small Firms That Cover Through the Exchange	5,508	
Workers and Dependents in Large Firms That Offer Private Coverage	7,440	
<b>Net Change In Employer Coverage Under The Obama Plan</b>		<b>4,636</b>

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

These losses of coverage would be more than offset by increases in the number of firms offering coverage. About 13.7 million workers and dependents would become newly covered under an employer plan as a result of the proposal. These include currently non-insuring employers who would find that their least costly approach would be to offer health insurance coverage. It also includes people who become covered due to their employer taking advantage of the tax credit program. In addition, it reflects the premium reductions resulting from the various cost containment initiatives. In addition, we estimate that about 525,000 currently uninsured people who are eligible for coverage through their employer would enroll in their employer's plan due to reduced premiums and the children's coverage mandate.

Finally, we estimate that many employers would obtain their coverage through the national exchange due to lower costs. These would represent about 13.4 million people in small firms who would become covered under the national exchange.

*Figure B-6* shows changes in private employer health spending assuming the program is fully implemented in 2010. We estimate that in 2010, private employers will spend about \$450.1 billion on health benefits, including benefits and administrative costs. This includes only the

portion paid by the employer. Of this, \$421.7 billion will be attributed to workers and dependents and \$28.5 billion will be for retirees.

**Figure B-6**  
**Change in Private Employer Health Benefit Costs by Current**  
**Insuring Status under the Obama Plan in 2010**  
**(billions)**

	<b>Currently Insuring Employers</b>	<b>Currently Non-Insuring Employers</b>	<b>All Employers</b>
<b>Private Employer Spending Under Current Policy</b>			
Current Cost of Coverage			
Workers and Dependents	\$421.7	\$0.0	\$421.7
Retirees	\$28.4	\$0.0	\$28.4
<b>Total Current Law</b>	<b>\$450.1</b>	<b>\$0.0</b>	<b>\$450.1</b>
<b>Private Employer Spending Under the Policy</b>			
Premiums for Employers in Exchange	\$42.9	\$12.6	\$55.5
Premiums for Employers in Private Market	\$376.3	\$15.4	\$391.7
Costs for Retirees	\$26.9	\$0.0	\$26.9
Health Care System Savings Initiatives	(\$4.8)	\$0.2	(\$5.0)
Cost Shift Savings	(\$2.3)	\$0.0	(\$2.3)
Small Employer Subsidies	(\$3.9)	(\$2.1)	(\$6.0)
Employer Reinsurance Program	(\$22.8)	(\$2.1)	(\$24.9)
Payroll Tax for Non-Insuring Firms	\$12.9	\$3.3	\$16.2
<b>Total Spending Under The Policy</b>	<b>\$425.2</b>	<b>\$26.9</b>	<b>\$452.1</b>
<b>Net Change in Private Employer Spending</b>			
<b>Net Change</b>	<b>(\$25.1)</b>	<b>\$27.1</b>	<b>\$2.0</b>

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

Under the Obama plan, benefits costs for currently insuring employers would decline by about \$25.1 billion, which is a savings of about 6.0 percent. Firms that do not currently offer insurance would spend \$27.1 billion for health care under the proposal.

Total federal spending for the reinsurance program and the small employer tax credit would be \$497.2 billion over ten years (*Figure B-7*). We assume that the threshold amount for the reinsurance program is indexed with annual health care cost growth to remain roughly 4 percent of employer health spending, as estimated by Obama campaign advisors.<sup>2</sup>

<sup>2</sup> Based upon a review of the economic literature, we assume that changes in employer costs resulting from these proposals would be passed on to workers in the form of changes in wage growth over time. Policies that reduce employer costs would result in a corresponding increase in wages for affected workers. Similarly, increases in employer health benefits costs are assumed to be passed on to workers as wage increases. HBSM also simulates the impact of these changes in wages upon federal and state tax revenues.

Figure B-7  
Federal Cost of the Reinsurance Program and the Tax Credit for Small Employers: 2010 - 2019  
(billions)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
Tax Credits For Small Employers	\$3.6	\$5.8	\$6.8	\$7.2	\$7.7	\$8.2	\$8.8	\$9.3	\$9.9	\$10.6	\$77.9
Reinsurance Program	\$28.2	\$33.3	\$35.5	\$37.8	\$40.3	\$42.9	\$45.7	\$48.6	\$51.8	\$55.2	\$419.2
<b>Total</b>	<b>\$31.8</b>	<b>\$39.1</b>	<b>\$42.3</b>	<b>\$45.1</b>	<b>\$48.0</b>	<b>\$51.1</b>	<b>\$54.4</b>	<b>\$58.0</b>	<b>\$61.7</b>	<b>\$65.7</b>	<b>\$497.2</b>

Source: The Lewin Group estimates.

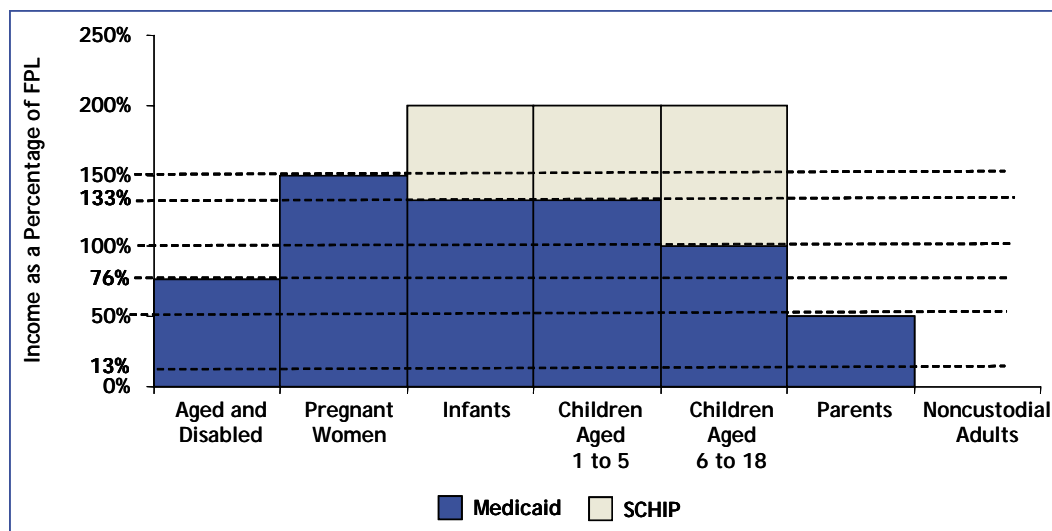
## B. Medicaid Expansion

The Obama plan would expand eligibility for the Medicaid and the State Children's Health Insurance Program (SCHIP). However, the campaign provides no information on who would become eligible or the states' responsibility to pay for these expansions. For illustrative purposes, we assumed that the program extends eligibility for all adults, including those without children, to 150 percent of the federal poverty level (FPL). We also assumed that the federal government would pay the full amount of the cost of covering these newly eligible populations. This formulation is consistent with the limited information the campaign has provided on the key features of the Medicaid expansion. We assume that the plan does not intend to create any unfunded mandate on states unless explicitly stated.

### 1. Current Program Eligibility

Medicaid and SCHIP are state-operated insurance programs covering low-income people that are funded with state revenues and federal matching funds. The income eligibility levels for these programs vary widely across states. *Figure B-8* presents an illustration of eligibility under a typical Medicaid program that is based upon the average income eligibility levels across all states.

Figure B-8  
Medicaid and SCHIP Eligibility for a “Typical State” Under Current Law<sup>a</sup>



a/ Figures roughly based upon average income eligibility levels across states by eligibility group.

Source: CMS program data.

Aged and disabled people typically are covered through 76 percent of the FPL (92 percent for couples). States are required to cover pregnant women through 133 percent of the FPL, but are permitted to set the eligibility level as high as 185 percent of the FPL. Federal law also requires states to cover children under age six years up to 133 percent of the FPL and children over age five years through the FPL. The SCHIP program covers children between the Medicaid income eligibility level and an average of about 200 percent of the FPL across the states.

States also are required to cover adults with custodial responsibilities for children through the income eligibility level for Temporary Assistance for Needy Families (TANF) and are permitted to cover parents with incomes as high as the SCHIP income eligibility level in each state. The income eligibility level for parents averages about 50 percent of FPL, but is as low as 13 percent of FPL in some states.<sup>3</sup> States do not receive federal matching funds to cover nondisabled, non-custodial adults at any income level, except in six states that have been granted a waiver to do so.

The federal medical assistance percentage (FMAP), which is the portion the federal government contributes towards the cost of Medicaid or SCHIP coverage, varies by state according to a formula that reflects differences in economic conditions. For the Medicaid program, the matching rate varies from 50 percent in some states to as high as 76 percent. The federal matching percentage for SCHIP is “enhanced” to between 65 percent and 83 percent across states.

<sup>3</sup> This is the income eligibility level for parents under the Aid to Families with Dependent Children program that was replaced under Temporary Assistance for Needy Families (TANF) Act.

The Congressional Budget Office (CBO) estimates that by 2010, federal spending will reach \$250.3 billion for Medicaid and \$5.0 billion for SCHIP. The Medicaid and SCHIP programs will cover 67 million people in 2010, of whom about half will be children.

## *2. Assumed Program Specifications*

Because the Obama plan does not provide details on their proposed Medicaid expansion, we defined an illustrative coverage expansion that is consistent with the limited detail provided by the campaign. We assumed the following:

- The program would raise the income eligibility levels in each state to at least 150 percent of the FPL, which is about \$32,000 for a family of four;
- All adults would be eligible including adults without custodial responsibilities for children;
- We assume there is no assets test for eligibility;
- The benefits provided under the program would be the same as those now provided in each state's Medicaid program; and
- We assume that the federal government would pay the full cost of the coverage expansion so that the plan does not create an "unfunded mandate" for states.

We assume that the program is implemented without a waiting period requirement or other provisions intended to reduce the number of people shifting from employer coverage to the program (i.e., anti "crowd-out" provisions).

## *3. Enrollment Assumptions*

We estimate that there are about 8.0 million uninsured people who are actually eligible for Medicaid or SCHIP but have not enrolled. Prior studies indicate that only about 70 percent of eligible people actually enroll. The reasons for non-enrollment are not fully understood. Lengthy enrollment processes and stigma often are cited as barriers to enrolling. However, there also is evidence that many eligible people do not enroll until they actually need health care.<sup>4</sup>

The Obama plan requirement that all children have coverage is likely to greatly increase enrollment of children in Medicaid, including many uninsured children who are eligible but not enrolled under current programs. In addition, enrollment rates for parents should improve as their children enroll in the program. Parents would largely be automatically enrolled once their children qualify for the program since parental income data already is collected for determining children's SCHIP eligibility. However, participation rates would remain an issue for noncustodial adults, who would be eligible only if they apply.

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<sup>4</sup> Medicaid has three month retrospective eligibility upon enrollment, which makes it possible to delay enrollment without forfeiting their eligibility once they become ill and need the coverage.

We estimated the number of people eligible for these coverage expansions using HBSM and the CPS data for 2006 and 2007.<sup>5</sup> Key assumptions in estimating enrollment and costs under the Obama plan include:

- We assume that all uninsured children in families with at least one school-age child become enrolled due to the children's coverage mandate (as discussed above, the campaign indicates that it will consider enrolling children through schools);
- We simulated enrollment for adults based upon a Lewin analysis of program participation rates under the current Medicaid program. This approach results in participation rates of about 70 percent for uninsured people and 45 percent for people who have access to insurance from some other source.
- The model estimates costs in HBSM from the data reported in the original MEPS, adjusted to 2010 levels. We also include an increase in utilization of health services for newly insured people. These imputations increase health services utilization to the levels reported by insured people with similar age, gender, income and health status characteristics. Our model estimates of costs per member per month (PMPM) are:
  - Parents: \$336 PMPM;
  - Non-custodial adults: \$420 PMPM; and
  - Children (currently eligible not enrolled): \$107 PMPM.
- We estimate that costs for currently eligible people who become enrolled under the proposal are 25 percent less than for currently enrolled people in their eligibility group.
- We assume that administrative costs per newly eligible person are equal to average administrative costs for eligibility functions per enrollee under the current program (\$170 per family per six-months of enrollment).
- We assume that there would be lags in enrollment in the first years of the program, as people learn of their eligibility and enroll. We assume that enrollment would lag by 60 percent in the first year and 20 percent in the second year, with no enrollment lags thereafter.

#### 4. Medicaid Expansion Estimates

*Figure B-9* presents estimates of the impact of the program on federal and state spending for Medicaid, assuming the program is fully implemented in 2010 with no lags in enrollment. Using the assumptions described above, we estimate that the number of people with Medicaid coverage would increase by about 16.7 million people. These include 13.4 million people (average monthly enrollment) who would have been uninsured in the absence of the program, and 3.3 million people who now have private coverage who would become enrolled under the program.

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<sup>5</sup> As discussed above, the CPS data for these years include a much expanded sample size designed to facilitate state level analyses. We have pooled the data for 2 years to further increase sample size for these analyses.

Federal spending for the Medicaid expansion would be \$71.2 billion. States would actually save about \$5.4 billion due to increases in employer coverage resulting from the various employer coverage provisions discussed above. We estimate that about 3.2 million of those now on Medicaid would become covered under private employer insurance as employer coverage is increased under the employer provisions of the Obama plan. This would reduce spending by \$7.2 billion for the federal government and \$5.4 billion for states.

We estimate that there are about 4.5 million uninsured children who are eligible for but not enrolled in the Medicaid or SCHIP programs. We estimate that 4.1 million of these children would become covered as a result of the children's coverage mandate under the Obama plan. As discussed above, we estimated enrollment assuming that the children's coverage mandate would require all parents to cover their children as a condition of entering school. The cost of this provision would be \$6.2 billion, all of which we assume would be paid by the federal government.

**Figure B-9**  
**Changes in Medicaid and SCHIP Spending Under the Obama Plan in 2010**

	Changes in Medicaid and SCHIP Enrollment (in 1,000s)	Reduction in Number of Uninsured (in 1,000s)	Changes in Medicaid and SCHIP Spending (in millions)		
			Total	Federal	State
Changes in Enrollment and Costs Under the Obama Plan					
Current Enrollees Shifting to Employer Coverage	(3,160)	N/A	(\$12,620)	(\$7,193)	(\$5,427)
Enrollment Increases for Currently Eligible Children					
Medicaid Children	3,013	2,567	\$3,936	\$3,936	\$0
SCHIP Children	1,840	1,568	\$2,276	\$2,276	\$0
Total	4,853	4,135	\$6,212	\$6,212	\$0
Eligibility Expansions					
Parents	3,353	1,930	\$13,524	\$13,524	\$0
Non-Custodial Adults	11,637	7,334	\$58,677	\$58,677	\$0
Total	14,990	9,264	\$72,201	\$72,201	\$0
Net Change	16,683	13,399	\$65,793	\$71,220	(\$5,427)

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

About 15.0 million adults would become enrolled under the plan, of which 77.6 percent (11.6 million) would be adults without custodial responsibility for children. The remainder would be parents in families who have incomes between current state income eligibility levels and 150 percent of the FPL.

**Figure B-10** presents estimates of the changes in spending for the state and federal governments under the Obama plan over the 2010 through 2019 period. These estimates reflect our



assumptions concerning lags in enrollment during the early years of the program. Federal spending under the Medicaid provisions of the Obama plan would be about \$910.9 billion over 2010 through 2019. State governments would save about \$71.1 billion over the same 10-year period.



Figure B-10:  
Federal and State Spending for Medicaid Under the Obama Plan: 2010 - 2019  
(millions)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
Federal Spending											
Shift to Employer Plans	-\$4,748	-\$6,901	-\$8,174	-\$8,714	-\$9,289	-\$9,902	-\$10,555	-\$11,252	-\$11,995	-\$12,786	-\$94,317
Children's Coverage	\$4,970	\$6,653	\$7,125	\$7,631	\$8,173	\$8,753	\$9,375	\$10,041	\$10,753	\$11,517	\$84,992
Expansion for Parents	\$5,410	\$11,533	\$15,368	\$16,382	\$17,464	\$18,616	\$19,845	\$21,155	\$22,551	\$24,039	\$172,363
Expansion for Non-custodial Adults	\$23,471	\$50,040	\$66,678	\$71,079	\$75,770	\$80,771	\$86,102	\$91,784	\$97,842	\$104,300	\$747,835
Total	\$29,102	\$61,325	\$80,997	\$86,379	\$92,118	\$98,238	\$104,766	\$111,727	\$119,152	\$127,069	\$910,873
State Spending											
Shift to Employer Plans	-\$3,582	-\$5,206	-\$6,167	-\$6,574	-\$7,007	-\$7,470	-\$7,963	-\$8,488	-\$9,049	-\$9,646	-\$71,151
Children's Coverage	0	0	0	0	0	0	0	0	0	0	0
Expansion for Parents	0	0	0	0	0	0	0	0	0	0	0
Expansion for non-Custodial Adults	0	0	0	0	0	0	0	0	0	0	0
Total	-\$3,582	-\$5,206	-\$6,167	-\$6,574	-\$7,007	-\$7,470	-\$7,963	-\$8,488	-\$9,049	-\$9,646	-\$71,151

Source: The Lewin Group estimates.

## C. Premium Subsidies and the National Exchange

The Obama proposal would provide subsidies for the purchase of insurance for people whose income is too high to qualify for Medicaid or SCHIP, but too low to be able to afford the full cost of insurance. The plan also creates a new publicly operated national health plan that is available to individuals without access to employer coverage, the self-employed and small firms. In addition, the plan would create a new national exchange offering a selection of private health plans as an alternative to the National Plan.

The methods we used to model the impact of these provisions are presented below.

### 1. Premium Subsidies

The Obama plan would provide subsidies to assist families in purchasing coverage under the newly created national plan or a private plan offered through the national exchange. The Obama plan specifies that the program would provide income-related premium subsidies to people who do not have access to employer coverage and who are not eligible for the expanded Medicaid and SCHIP programs. The campaign also indicates that the National Plan and other private plans in the exchange would be required to provide benefits that are similar to those provided to federal employees under the federal employees health benefits program (FEHBP). However, the Obama plan does not provide details on eligibility or subsidy levels.

For illustrative purposes, we have specified the details of a premium subsidy program that is consistent with what the campaign has published. We assume that the program would pay a percentage of the premium on a sliding scale with income for people purchasing coverage through the exchange, including the National Plan, who do not have access to employer health coverage. Thus the subsidies are not available to anyone offered coverage through employment.

The program would be available to people with incomes too high to qualify for Medicaid, which we have assumed to be 150 percent of the FPL. We assume that the subsidies would vary from 100 percent of the premium at 150 percent of the FPL to zero percent of the premium at 400 percent of the FPL (\$80,000 for a family of four). We assume that premium subsidies are available only through the exchange, which includes private plans and the National Plan.

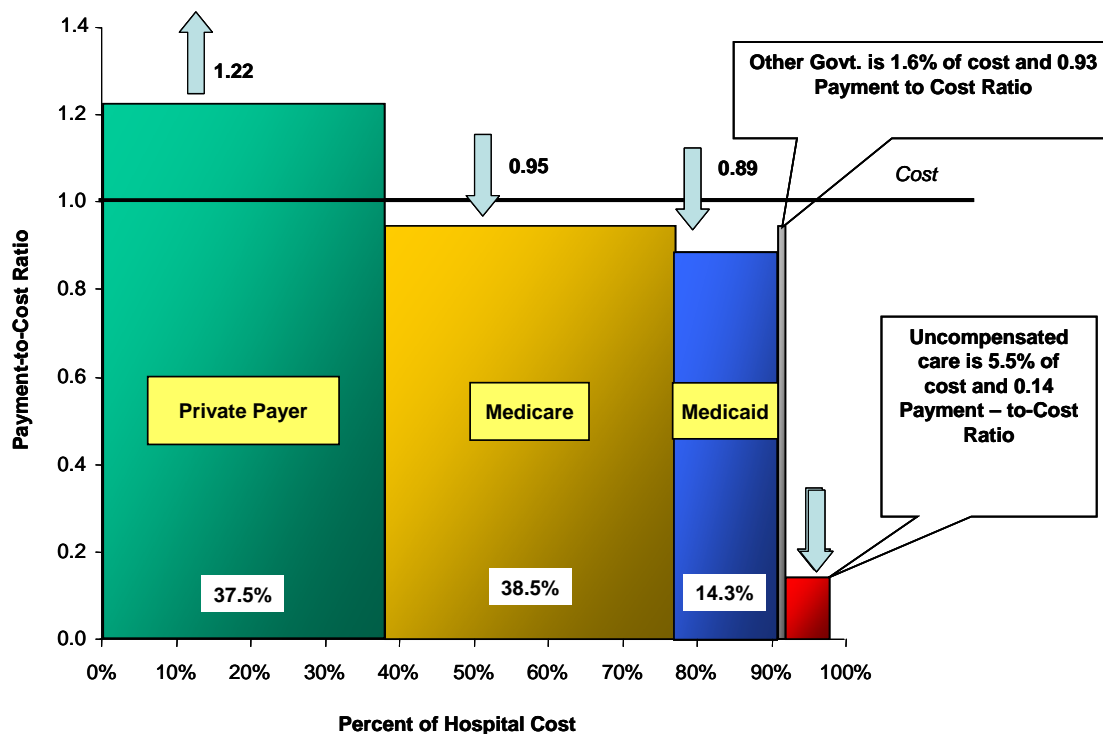
### 2. The National Plan

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

The cost of this option is largely dependent upon the payment levels for providers under the plan. For example, hospital payment levels under the Medicare program are about 25 percent below payment levels under private health plans *Figure B-11*. Larger payment differentials exist for physician care. Thus the choice of payment systems will drive the premium levels under the

plan. This will also drive enrollment since people will be attracted to the plan if premiums are substantially lower than for private coverage.

Figure B-11  
Average Payment-to-cost Ratios for Hospitals by Payer Group Nationally for 2002



Source: Al Dobson, Joan DaVanzo and Namrata Sen, "The Cost-Shift Payment 'Hydraulic': Foundation, History, and Implications," *Health Affairs*, January/February 2006, volume 25, number 1.

However, the Obama plan does not specify the basis for provider payments. While some of the presidential candidates proposed to establish such a plan based upon the Medicare model, the Obama plan does not describe the program as a "Medicare-like" plan. For illustrative purposes, we assume that payment levels would be set at levels that for hospitals are equal to 105 percent of costs, with a proportionate adjustment for physician's care.

We assume that this payment level adjustment accounts for increases in utilization that typically occur after reductions in payment levels under Medicare and other programs. We assumed that administrative costs under the public plan would be lower than for comparable private insurance because it would exclude profits and broker and agent commissions. Using these assumptions, we estimate that the premium for the National Plan would be about 25 percent lower than for typical private insurance plans.

### 3. National Exchange

The Obama plan would create a national "exchange" that would offer a selection of coverage options including the National Plan and private coverage options. All plans participating in the exchange are required to cover at least the same FEHBP benefits offered by the National Plan.

The exchange would provide consumers with the materials required to compare and evaluate the coverage options.

Because the Obama plan is lacking in detail, we made several assumptions on the operation of the exchange. We assume that all firms with fewer than 25 workers are eligible to buy into the exchange. We also assume that premium subsidies are available only to those enrolling through the exchange. This is intended to draw a more representative sample of the eligible population to avoid adverse selection and premium spirals. We assume that the premium charged for all insurance in the exchange, including the National Plan, is based upon the full cost of benefits and administrative costs under the plan.

#### 4. Administrative Costs

The Obama proposal seeks to use the exchange and the National Plan as a means of reducing administrative costs in the current system. Administrative costs are often equal to as much as 40 percent of covered benefits for individual coverage, and up to 30 percent of benefits for small employers. By comparison, administrative costs in very large employer groups can be as little as 3.4 percent of claims, reflecting significant economies of scale in large groups.

The national exchange would attempt to realize these economies of scale for individual and small groups. It would do this by using the exchange to organize people selecting each plan into a single list of several thousands of people that would be transferred to the insurers with the premium amounts. While this would reduce the insurer's cost of administering insurance, it will create a substantial administrative burden for the exchange that would now take over the functions of administering the selection of plans and premium payments from several million individuals and small employers. Thus, the exchange merely shifts much of the cost of administering individual and small group coverage to the exchange.

For example, the Health Insurance Purchasing Cooperative (HIPC) for small employers (i.e., fewer than 50 workers) in California performs a similar role in administering plan selection and premium payment for employers choosing to purchase coverage through the HIPC. The HIPC reports that its administrative costs are covered through a premium add-on of about 4.5 percent of premium. This is in addition to the insurer's cost of administering insurance. In a study of purchasing cooperatives throughout the country, Long and Marquis (1999) found little difference between the premiums charged in the pool and the premiums charged in the commercial market.<sup>6</sup> Another study of a purchasing alliance in California also found little evidence of administrative savings.<sup>7</sup>

For these reasons, the cost of administering coverage for individuals and employer groups of varying sizes probably would not be much different than for any other insurer. Savings of 6 percent to 8 percent can be realized for individuals and very small groups if the pool does not

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<sup>6</sup> Long, S. and Marquis S., "Pooled Purchasing: Who are the Players?," *Health Affairs*, vol. 18, no. 4 (July/August 1999), pp 105-111.

<sup>7</sup> Yegian, J. et al., "Health Insurance Purchasing Alliances for Small Firms: Lessons From the California Experience (Oakland, Calif.: California HealthCare Foundation, May 1998).

use insurance agents and brokers who are paid through commission. However, enrollment in pools that do not pay commissions to insurance agents and brokers has tended to be low.

*Figure B-12* compares our estimates of the cost of administering insurance under the existing system and under the exchange. These include administrative cost for both the insurers and the exchange itself. We adjusted these estimates to reflect the following changes:

- The source of coverage often will not change when people change jobs or exit the labor force if their employers tend to be small firms, many of whom would participate in the exchange;
- Coverage is standardized; and
- Medical underwriting is eliminated.

We estimated private insurer costs based upon a study of various components of insurer administrative costs conducted by the Hay Group in a study of insurance pooling models for the Congressional Research Service (CRS). The study provided data on insurer administrative costs as a percentage of claims under current law and under an insurance pool with a selection of health plans, similar in design to the exchange. We modified these administrative cost percentages for current law to reflect actual administrative costs in the exchange.

In addition, we assume that administrative costs in the National Plan would exclude broker commissions and insurer profit. This further reduces administrative cost by 25 percent in the National Plan.

**Figure B-12**  
**Cost of Administering Health Insurance as a Percentage of Claims under Current Law and the Proposed Exchange <sup>a/</sup>**

Size of Group	Claims Administration		General Administration		Interest Credit		Risk / Profit		Commissions		Total Administrative	
	Current	Exchange	Current	Exchange	Current	Exchange	Current	Exchange	Current	Exchange	Current	Exchange
Individuals	10.9%	5.4%	19.0%	6.5%	-1.1%	-1.1%	8.7%	2.7%	3.4%	1.0%	40.9%	14.5%
2 to 4	9.5	4.7	14.7	5.7	-1.1	-1.1	6.4	2.3	3.1	1.0	35.8	13.3
5 to 9	8.8	4.7	13.2	5.7	-1.1	-1.1	6.0	2.3	2.2	1.0	31.1	13.3
10 to 19	7.4	4.7	10.8	5.2	-1.1	-1.1	5.6	2.3	1.9	1.0	26.5	12.8
20 to 49	6.5	4.3	8.9	4.7	-1.1	-1.1	5.1	2.3	1.2	1.0	21.8	11.9
50 to 99	4.4	3.8	5.6	3.2	-1.1	-1.1	4.5	2.3	0.7	1.0	15.3	9.9
100 to 499	4.2	3.8	4.7	2.8	-1.1	-1.1	4.1	2.3	0.6	1.0	13.5	9.5
500 to 2,499	4.0	3.6	4.6	3.0	-1.1	-1.1	2.6	2.3	0.3	1.0	10.4	9.5
2,500 to 9,999	3.9	3.5	2.0	1.4	-1.1	-1.1	1.4	1.4	\$6.0 <sup>b/</sup>	1.0	6.7	6.6
10,000 +	3.1	2.8	0.9	0.7	-1.1	-1.1	0.8	0.8	\$6.0 <sup>b/</sup>	1.0	4.5	4.5
<b>Total</b>	<b>4.8%</b>	<b>3.9%</b>	<b>5.0%</b>	<b>3.4%</b>	<b>-1.1%</b>	<b>-1.1%</b>	<b>3.0%</b>	<b>2.0%</b>	<b>1.1%</b>	<b>1.0%</b>	<b>12.7%</b>	<b>9.4%</b>

a/ Only small firms are permitted to enter the exchange, which we assume includes firms with fewer than 25 workers.

b/ Self-funded plans pay a fee of about \$6.0 per worker per month. We assume that all firms with 2,500 or more workers are self-funded.

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.

## 5. Enrollment in the Exchange and the National Plan

We simulated enrollment in the national exchange and the national health plan based upon the cost of coverage in the exchange versus the cost of coverage in the existing private market. Though conceptually similar, we used separate processes to simulate enrollment for small employers and individuals. We simulate these decisions based upon the cost of coverage in the national exchange and the National Plan.

We estimate that private coverage alternatives in the national exchange are about 15 percent less than comparable coverage outside of the exchange due to savings in administration. Coverage in the National Plan would be about 25 percent less costly than in the current private insurance markets. This reflects the lower cost of administration in the exchange and the lower provider payment levels used in the plan (as discussed above, we assume the National Plan uses payment levels that are about 10 percent lower than in private insurance plans).

## 6. Individuals and Self-employed

Because premium subsidies for individuals under the plan are available only in the exchange, we assume that all of those purchasing individual coverage who are eligible for premium subsidies would enroll in a plan participating in the exchange.

Some of those who currently have non-group coverage will move to the exchange due to the lower cost of coverage there. We base these estimates on statistical analyses of the impact of changes in the relative price of insurance for alternative health plans in firms that now offer a choice of coverage. These data indicate an overall average price elasticity of -2.47. (This elasticity is an estimate of the percentage change in enrollment for a health plan given a 1 percent change in the premium for that plan.) The elasticity ranges from -3.5 for people under the age of 31 years who are a low health care risk to -1.38 for high risk individuals over the age of 45 years.<sup>8</sup>

Using these data, we simulated the likelihood that an individual would shift from their existing private coverage to a private plan in the exchange. We then simulate the number of people with private coverage who shift to the National Plan, reflecting the lower premium in that plan.

For previously uninsured people who decide to purchase individual coverage due to the lower cost of insurance in the exchange and the premium subsidies, we simulate the number of people who would select the National Plan reflecting the lower premium in that plan using a similar methodology to that described above.

## 7. Small Employers

As discussed above, we assume that firms with less than 25 workers would be eligible to participate in the exchange and the National plan. We simulated this decision based upon a variation on a “voting” model using the elasticity estimates presented above. We do this by

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<sup>8</sup> Strombom, Bruce A., Buchmueller, Thomas C., Feldstein, Paul J., “Switching Costs, Price Sensitivity and Health Plan Choice,” *Journal of Health Economics*, October 2001.



estimating the likelihood that each individual in each group would change coverage due to the lower premiums charged in the exchange. We then average the estimated likelihoods across all workers and form a composite probability of changing coverage. The process for selecting firms to enter the exchange and the National Plan for small groups was modeled in the same way as we modeled the decision for individuals to move to these plans.

### 8. Premium Subsidy Program Costs

We simulate enrollment in the program using an HBSM model of how the likelihood of purchasing coverage changes as the premium changes. For each person who is not covered under an employer plan or Medicaid/SCHIP, we first estimated the cost of purchasing non-group coverage under current law, given the rating rules that now apply. We then estimated the premium that these individuals would pay if they purchase coverage under the Obama plan. This reflects the following changes under the Obama plan:

- New insurance market regulations requiring guaranteed issue of coverage and prohibiting health status rating. Premiums increase for some while they go down for others;
- The cost of coverage under the National Plan, including the lower provider payment levels and reduced administrative costs; and
- Premium subsidies.

We then estimated changes in coverage under the proposal based upon the changes in premiums. Changes in coverage were estimated using estimates of the price elasticity of insurance coverage. These price elasticity estimates, described in *Appendix A*, show that each percentage point change in premiums is associated with a 0.34 percent change in the probability of taking coverage.

Under this approach, we estimated that some of those now purchasing coverage in the non-group market would discontinue their coverage in instances where the insurance market rating reforms increased premiums. Similarly, many of those who do not now have coverage will obtain it in the exchange.

We estimate that about 12.2 million people would enroll in the premium subsidy program (*Figure B-13*). This includes people who do not obtain employer coverage under the program. The program would cost the federal government about \$25.9 billion assuming full implementation in 2010. *Figure B-14* presents premium subsidy costs over the 2010 through 2019 period which reflects expected lags in enrollment.



**Figure B-13**  
**Individual Market Enrollment and Premium Subsidy Costs under the Obama Plan in 2010**

	Number of People (1,000s)	Number People Receiving Subsidies (1,000s)	Cost of Premium Subsidies (millions)
<b>Currently Insured Through Private Individual Coverage <sup>a/</sup></b>			
Take Coverage Under National Plan	7,828	4,679	\$6,711
Coverage Through Private Plans in the Exchange	2,318	1,562	\$5,452
Retain Private Individual Coverage Outside of Exchange	1,131	N/A	N/A
<b>Total</b>	<b>11,277</b>	<b>6,241</b>	<b>\$12,163</b>
<b>Currently Uninsured Who Purchase Individual Coverage</b>			
Take Coverage Under National Plan	3,592	2,639	\$4,756
Coverage Through Private Plans in the Exchange	2,099	1,424	\$3,545
<b>Total</b>	<b>5,691</b>	<b>4,063</b>	<b>\$8,302</b>
<b>Workers and Dependents Whose Employer Discontinues Coverage</b>			
Take Coverage Under National Plan	1,487	1,168	\$2,912
Coverage Through Private Plans in the Exchange	812	728	\$2,478
Take Private Individual Coverage Outside of Exchange	126	N/A	N/A
<b>Total</b>	<b>2,425</b>	<b>1,896</b>	<b>\$5,390</b>
Program Administration of Subsidies	N/A	N/A	\$2,800
<b>Total</b>	<b>19,393</b>	<b>12,200</b>	<b>\$28,655</b>

a/ There are 14.3 million people currently covered in the individual market. We estimate that 11.3 million will retain individual coverage, 2.0 million will take newly offered employer coverage, 790,000 will enroll in the Medicaid expansions, and 162,000 will go uninsured.

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

**Figure B-14**  
**Annual Cost of the Obama Premium Subsidy Program**  
**(billions)**

2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-19
\$11.4	\$24.4	\$32.6	\$34.7	\$37.0	\$39.5	\$42.1	\$44.9	\$47.9	\$51.1	\$365.6

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

## D. Prescription Drug Provisions

The Obama plan includes three provisions to help limit the cost of prescription drugs. These include:

- Permit re-importation of prescription drugs;
- Repeal the ban on direct negotiation with drug companies for drugs purchased under the Medicare Part D program; and
- Prohibit drug companies from taking steps to keep generics out of the drug market.

These provisions are discussed below.

### 1. Prescription Drug Re-importation

The CBO estimates that prescription drug prices are 35 percent to 55 percent lower in other countries than in the US for the same drugs.<sup>9</sup> Prices are lower in other countries, partly because some countries place limits on the prices that can be charged for individual drugs. The main reason for price disparities is that drug companies are free to set prices at lower levels in markets less willing to pay US-level prices, so as to maximize sales and profitability in any given market area. This is particularly true for drugs protected by patents that effectively eliminate price competition in cases where there is no therapeutic alternative.

This has led plans to permit re-importation of drugs acquired in these countries for resale and use in the US. The Medicare Modernization Act of 2003 (MMA), permits the re-importation of drugs from Canada, contingent upon the HHS Secretary's certification of the drug's safety. However, to date, no such certifications have been provided. The Obama plan would permit re-importation of drugs from other countries, subject to safety constraints.

The CBO estimated that a similar piece of legislation passed by the US House of Representatives in July 2003 (HR 2427) would have reduced drug prices in the US by about one percent.<sup>10</sup> There are several reasons why these savings would be small, including:

1. Drug companies could adopt contract restrictions with foreign wholesalers prohibiting resale for export.
2. Drug manufacturers could differentiate products distributed overseas by size, shape or color, all of which are subject to FDA regulations, thereby preventing distribution in the US as approved products.
3. Foreign regulators could limit or prohibit export to avoid shortages in their own countries.

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<sup>9</sup> Baker C., "Would Prescription Drug Re-importation Reduce U.S. Drug Spending," *Almanac of Policy Issues*, April 24, 2004, Congressional Budget Office.

<sup>10</sup> Congressional Budget Office, H.R. 2427: The Pharmaceutical Market Access Act of 2003, CBO Cost Estimate (November 2003).

Based upon the CBO estimate, we assume savings to be one percent for both public and private payers. Our estimates of drug re-importation savings are presented in *Figure B-15* for Medicare and private payers.

**Figure B-15**  
Savings from Prescription Drug Provisions of the Obama Plan: 2010 - 2019  
(billions)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
<b>Medicare</b>											
Drug Re-importation Program	\$0.7	\$0.7	\$0.8	\$0.9	\$1.0	\$1.1	\$1.2	\$1.2	\$1.3	\$1.4	\$10.3
Medicare Price Negotiations	\$1.1	\$1.3	\$1.2	\$1.5	\$1.6	\$1.8	\$2.1	\$2.3	\$2.5	\$2.6	\$18.0
<b>Total Medicare Only</b>	<b>\$1.8</b>	<b>\$2.0</b>	<b>\$2.0</b>	<b>\$2.4</b>	<b>\$2.6</b>	<b>\$2.9</b>	<b>\$3.3</b>	<b>\$3.5</b>	<b>\$3.8</b>	<b>\$4.0</b>	<b>\$28.3</b>
<b>Private Insurance</b>											
Drug Re-importation Program	\$2.0	\$2.2	\$2.4	\$2.7	\$3.0	\$3.3	\$3.6	\$4.0	\$4.3	\$4.8	\$32.3
<b>Total Medicare and Private</b>											
<b>Total</b>	<b>\$3.8</b>	<b>\$4.2</b>	<b>\$4.4</b>	<b>\$5.1</b>	<b>\$5.6</b>	<b>\$6.2</b>	<b>\$6.9</b>	<b>\$7.5</b>	<b>\$8.1</b>	<b>\$8.8</b>	<b>\$60.6</b>

Source: The Lewin Group estimates.

## *2. Negotiate Lower Prices with Drug Companies*

The Obama plan would permit the Secretary of the Health and Human Services to attempt to negotiate lower prices for prescription drugs for federal programs, including the new Medicare benefit. Under the recently-enacted Medicare drug program, beneficiaries typically will obtain coverage through private health plans, Pharmacy Benefits Management (PBM) companies or employer-sponsoring retiree health plans. The program relies upon these plans to negotiate the lowest prices possible for the Medicare beneficiaries that they will cover.

In the Medicare Modernization Act of 2003 (MMA), the language of the statute explicitly forbade the Secretary from interfering in the price negotiations between the drug manufacturers, pharmacies, Part D Plans (PDPs), or their sponsors. In addition, the Secretary was forbidden from instituting a formulary or price structure for the reimbursement of Part D drugs. The rationale for this was that the PDPs and Medicare Advantage Part D Plans (MAPDs) could do a better job at negotiating discounts with drug manufacturers than the government. This provision of the Obama plan would attempt to negotiate even better prices for the Medicare program.

A key element to negotiating discounts is the credible threat that, if the manufacturer does not agree to a competitive price, the plan will not cover their drug. Under the Medicare bill, this is accomplished by permitting health plans to use formularies that can exclude pharmaceuticals

that are not price-competitive with their therapeutic alternative medications. In a recent analysis of this issue, the CBO indicated its opinion that the health plans serving Medicare beneficiaries already have the incentives and leverage required to negotiate with manufacturers for single-source drugs (i.e., patented compounds for which there are no generic alternatives) where therapeutic alternatives are available (i.e., competing single-source drugs).<sup>11</sup>

However, the CBO indicated that price negotiations could be ineffective in reducing costs for single-source drugs for which there are no therapeutic alternatives.<sup>12</sup> This is because health plans cannot exclude from their formularies drugs for which there are no substitutes. Despite the drug manufacturers' monopoly position with these drugs, they may be willing to negotiate discounts to avoid negatively influencing public opinion and policymakers. However, there is nothing to guarantee that manufacturers would not increase prices to other payers to maintain income from these products.<sup>13</sup>

We used industry pharmacy tracking data on prescribed drugs to estimate the percentage of prescription drug spending associated with single-source drugs where there are no therapeutic alternatives.<sup>14</sup> These data indicate that about 2.7 percent of all prescription drug spending is for such drugs. We assume that the discounts negotiated for these drugs would average about 16 percent. This is an estimate of the average difference between the average wholesale price (AWP) and the final cost to the purchaser, reflecting discounts and rebates.<sup>15</sup> Total savings to the Medicare program would be about \$0.5 billion over the 10-year period from 2006 through 2015.

The Federal government accrues a net savings of \$6.7 billion over 5 years and \$18.2 billion over ten years (*Figure B-16*).

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<sup>11</sup> Letter from Douglas Holtz-Eakin, Director, Congressional Budget Office, to Honorable Ron Wyden, United States Senate, March 3, 2004.

<sup>12</sup> Letter from Peter R. Orszag, Director, Congressional Budget Office, to Honorable Ron Wyden, United States Senate, April 10, 2007.

<sup>13</sup> Newhouse J., "How Much Should Medicare Pay for Drugs?," *Health Affairs*, 2004, Volume 23, Number 1.

<sup>14</sup> Verispan, Vector One; Quintiles Transnational data, 2004.

<sup>15</sup> "Prescription Drug Coverage, Spending, Utilization and Prices: Report to the President," Department of Health and Human Services (HHS), April 2000; We assume average manufacturer rebates of 8% for PBMs.

**Figure B-16**  
**Savings to Part D from Direct Negotiation of Drug Prices for Single-Source and Unique Drugs**  
**(billions)**

Year	Projected Drug Spending on Unique Drugs under Current Law <sup>a/</sup>	Projected Drug spending on Unique Drugs under Policy	Projected Savings to Part D under Policy
2010	\$7.2	\$6.1	\$1.1
2011	\$8.6	\$7.3	\$1.3
2012	\$8.1	\$6.9	\$1.2
2013	\$9.8	\$8.3	\$1.5
2014	\$11.0	\$9.3	\$1.6
2015	\$12.3	\$10.4	\$1.8
2016	\$14.9	\$12.7	\$2.1
2017	\$15.5	\$13.2	\$2.3
2018	\$16.1	\$13.7	\$2.5
2019	\$16.9	\$14.3	\$2.6
2010-2014	\$44.7	\$37.9	\$6.7
2010-2019	\$120.4	\$102.4	\$18.0

a/ Based on 11 percent of all Part D expenditures. 2007 CBO Medicare Baseline.  
Source: The Lewin Group estimates.

There are other proposals to reduce spending on prescription drugs under Part B that are not included in the Obama plan. For example, Medicare payments for drugs under Part D for Medicare/Medicaid dual eligible people are higher than they were for these people under Medicaid. Using Medicaid payment rates for the dual eligible population would reduce federal spending. Newhouse (2007) also suggests using competitive bidding to select PBMs to handle all purchases for all Part D beneficiaries within each geographic region.

## **E. Eliminate Medicare Health Plan Overpayments**

In 2003, the Medicare Modernization Act (MMA) created the Medicare Advantage program (MA). Medicare Advantage was designed to expand and improve upon its predecessor, Medicare + Choice (M+C) by expanding coverage choices through private health plans and providing a prescription drug benefit. To promote plan participation, provisions in the statute defined county payment rates to participating plans above the comparable fee-for-service (FFS) costs in the counties.

The resulting “excess” payment is estimated to be 12 percent over the county FFS costs. However, Congress recently adopted a phase-out of the portion of the payment attributed to indirect medical education (IME) – this measure was included in the Medicare Improvements for Patients and Providers Act of 2008. This has the effect of reducing, but not eliminating, the overpayment.

This policy option would re-calibrate the benchmark rate to the FFS per-capita-costs, eliminating excess payment due to differences between the existing benchmark rate and the FFS

per-capita costs. We estimate a total reduction in federal spending of \$135.3 billion over the 2010 through 2019 period (*Figure B-17*).

**Figure B-17**  
**Federal Savings from Eliminating Medicare Advantage Overpayments**  
**(billions)**

2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
\$13.0	\$13.3	\$10.8	\$10.8	\$11.5	\$12.5	\$12.9	\$14.8	\$16.8	\$18.9	\$59.4	\$135.3

Source: The Lewin Group estimates.

## F. Comparative Effectiveness Research

The Obama plan would establish an institute to guide reviews and research on comparative effectiveness of alternative diagnostic and therapeutic interventions. The findings would be used to provide accurate and objective information in support of decisions made by doctors and patients. This proposal arises from research showing substantial overuse of care by some while many others go without needed care. Fisher and Wennberg et al. (2003) provide extensive evidence of wide variations in medical practice across the country that finds little relationship between the amount of spending and outcomes. They have suggested that reducing this practice variation could reduce Medicare costs by up to 30 percent.<sup>16</sup>

We assume that the information generated by this effort and intended for use by doctors and patients would be incorporated into practice guidelines, standards, and other evidence-based decision support. We refer to these resources collectively here as evidence-based medicine (EBM) guidelines. In this section we describe the research on adherence to medical guidelines under current law and the methods we used to estimate savings if providers comply with such guidelines.

### 1. Background

A large number of practice guidelines already exist. Based upon input from prominent researchers in this field, we estimate that practice guidelines, including those recognized as evidence-based, exist for health care services accounting for between 20 percent and 33 percent of all health spending for the chronically ill. However, the literature on the use of evidence-based medicine (EBM) findings in practice provides extensive evidence that adherence to such guidelines is quite low. A meta-analysis of studies of adherence to practice guidelines for multiple conditions by Burstin (1999) showed an average of 54.5 percent adherence to clinical guidelines.<sup>17</sup> Examples of this research include:

<sup>16</sup> Wennberg et al. (2003), "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care". *Annals of Internal Medicine*, February 18, 2003, Vol 138.

<sup>17</sup> H. R. Burstin, et al., "Benchmarking Quality Improvement: the Harvard Emergency Department Quality Study," *American Journal of Medicine*, 1999, 107:437-440.

- A study of adherence to practice guidelines for managing osteoporosis showed that adherence among practice sites ranged from 17 percent to 71 percent;<sup>18</sup>
- A 1995 survey of emergency department directors found that only 45 percent were aware of guidelines issued four years prior for asthma, and only 24 percent said they had read them;<sup>19</sup>
- In a recent study of Mayo Clinic, Pena (2007) found only 25 percent compliance with guidelines for uncomplicated urinary track infection;<sup>20</sup> and
- A national survey of pediatricians showed that more 88 percent of physicians surveyed knew of asthma guidelines, but only 35 percent followed them.<sup>21</sup>

Several studies explore the reasons for low adherence to guidelines. Cabana et al. (1999) identified three general categories of barriers: physician knowledge (which includes lack of awareness or familiarity with guidelines), attitudes (including lack of self-efficacy, lack of agreement, lack of outcome expectancy, and inertia of previous practice), and external barriers. Of these barriers, lack of familiarity with guidelines was most common (56.5 percent), followed by lack of awareness (54.5 percent), lack of outcome expectancy (26.0 percent), and lack of self-efficacy (13.0 percent).<sup>22</sup>

## 2. Features That Improve Adherence

Several researchers have explored the effectiveness of alternative methods for increasing the share of physicians that follow relevant guidelines. The current system for disseminating guideline information relies largely on physician initiative, mass mailings and unsolicited conferences. Gallagher (2002) found in a review of dissemination studies that these approaches were not effective in raising the providers' awareness to a level at which they would influence practice patterns. He also found that the distribution of audiovisual information was ineffective.<sup>23</sup>

Another dissemination approach is tied to physician profiling. In this approach, physicians who appear to be practicing outside of the guidelines are identified for education on the existence and proper use of guidelines. Physician profiling coupled with direct intervention with

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<sup>18</sup> Daniel H. Solomon, "Adherence with Osteoporosis Practice Guidelines: A Multilevel Analysis of Patient, Physician, and Practice Setting Characteristics," *The American Journal of Medicine*, vol. 117, December, 2004.

<sup>19</sup> E.F. Crain et al., "Pediatric Asthma Care in U.S. Emergency Departments," *Archives of Pediatric and Adolescent Medicine*, 149 no. 8 (1995)

<sup>20</sup> Adolfo Pena, MD, "Physicians' Beliefs and Evidence Based Medicine," *Med Educ Online*, 2007: 12, available at [www.med-ed-online.org](http://www.med-ed-online.org).

<sup>21</sup> Flores et al., "Pediatricians' Attitudes, Beliefs, and Practice." Regarding Clinical Practice Guideline: A National Survey," *Pediatrics*, Vol. 105, No. 3, March 2000.

<sup>22</sup> Michael D. Cabana; Cynthia S. Rand, Neil R. Powe, et al., "Why Don't Physicians Follow Clinical Practice Guidelines?: A Framework for Improvement." *Journal of the American Medical Association (JAMA)*. 1999; 282(15); 1458-1465.

<sup>23</sup> Gallagher, J. "How Well Do Clinical Practice Guidelines Guide Clinical Practice?" *Annals of Emergency Medicine*, October 2002



physician education has been shown to improve adherence to clinical practice guidelines and generate cost savings.<sup>24</sup>

A study of a group of physicians in HMOs visited by trained physicians to discuss the guidelines and supporting research experienced a net savings of \$285 per physician. No savings were found when the individualized physician visits were replaced with 45-minute meetings with a group of seven or eight physicians.<sup>25</sup> While the use of individualized interventions seems promising within HMOs, it is not clear whether this result would be replicated in a non-HMO setting. Moreover, individualized interventions cost about \$7,200 per physician, compared with a cost of about \$700 per physician under the group intervention model.

Health information systems could improve adherence by providing evidence-based suggestions on treatment of chronic conditions using information included in the electronic medical record. Tierney (2003) indicates that experience with such systems in the treatment of the chronically ill has been mixed. Tierney conducted trials where physicians were provided with evidence-based suggestions and found that it failed to improve physicians' and pharmacists' adherence for heart disease patients.<sup>26</sup>

Some researchers have said that changes in physician incentives are required to realize fuller adherence to guidelines.<sup>27</sup> For example, paying physicians more when they practice according to medical practice guidelines could increase adherence. Increasing patient copayments when guidelines are not followed could also create pressure for providers to comply with guidelines.

### 3. Methodology

We estimated the impact of the comparative effectiveness proposal based on the available research on the effectiveness of clinical guidelines on the practice of medicine. We assume that the number of new medical guidelines in each year would increase in proportion to the funding provided for the research. We then estimated their effect on medical practice based on research on the level of adherence to guidelines in today's system. Savings were estimated based upon research showing the share of health spending that is considered to be ineffective.

We assume that the program would be funded at \$900 million per year, indexed annually to health care cost growth.<sup>28</sup> This is an increase in spending on clinical guidelines nationally of about 2.0 percent, which should be achievable without diminishing the quality of research. Based on input from researchers in this field, we assume that by 2010, guidelines will exist for about 30 percent of chronic care services.

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<sup>24</sup> Lee et al., "Managed Care Provider Profiling" *Journal of Insurance Medicine*, Volume 24, No. 3, Fall 1992.

<sup>25</sup> Simon et al., "Economic Analysis of a Randomized Trial of Academic Detailing Interventions to Improve Use of Antihypertensive Medications," *Journal of Clinical Hypertension*, 9(1), pp. 15-20, January 2007.

<sup>26</sup> W.M. Tierney et al., "Effects of Computerized Guidelines for Managing Health Disease in Primary Care," (HS07763. *Journal of General Medicine* 18:967-976, December 2003.

<sup>27</sup> Lomas et al., "Do Practice Guidelines Guide Practice? The Effect of a Consensus Statement on the Practice of Physicians," *New England Journal of Medicine*, Volume 321:1306-1311, November 1989.

<sup>28</sup> Reflects the savings achieved from translation of the guidelines findings into practice, net of the costs of the institute in conducting review and research.



The literature provides evidence that adherence to guidelines is greater in managed care and care provided in disease management programs. We assume the following levels of adherence:

- Based on researcher input, we assumed that, prior to the promulgation of a new guideline, about 40 percent of physicians already would be practicing in a manner largely consistent with the guideline.
- We use the adherence rates cited in Byrd et al. (1999) of 45 percent in FFS plans and 83 percent for managed care plans.<sup>29</sup>
- Using adherence data from Horning et al. (2007), we estimated an adherence rate of 59.9 percent for patients in disease management programs.<sup>30</sup>

We then estimated the rate at which new guidelines are being developed under current law, based on historical data from the National Guideline Clearinghouse (NGC). These data indicate that the number of guidelines available will increase by about 2.4 percent per year under current law.<sup>31</sup>

Based on the cost per new guideline and the funding provided under the proposal, we estimated that the number of new guidelines would increase by 1.2 percentage points per year under the proposal. This assumes that many of the new guidelines would be based on existing clinical research.

We assume that guidelines will pertain to care for chronic health conditions, which Thorpe (2007) estimates comprise about 75 percent of health spending.<sup>32</sup> We also use the Fisher and Wennberg (2003) estimate that 30 percent of care is potentially unnecessary or ineffective.

Using these assumptions, we estimate physician compliance with evidence-based guidelines would reduce spending for health services by about \$52.0 billion over the 2010 through 2019 period (*Figure B-18*). Savings would be \$26.4 billion in managed care plans, \$15.8 billion in FFS plans with disease management, and \$9.8 billion in the remainder of the system (numbers not shown). Program costs over the 10 years would be \$11.1 billion, resulting in a net savings of about \$39.9 billion over this period.

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<sup>29</sup> Byrd et al., "Adherence to AAP Guidelines for Well-Child Care Under Managed Care," *Pediatrics*, Vol. 104, September 1999, pp. 536-540.

<sup>30</sup> Horning et al. (2007) "Adherence to Clinical Practice Guidelines for 7 Chronic Conditions in Long-Term-Care Patients Who Received Pharmacist Disease Management Services Versus Traditional Drug Regimen Review", *Journal of Managed Care Pharmacy*, January/February 2007, Vol. 13 No. 1.

<sup>31</sup> The NGC is an initiative of the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. NGC was originally created by AHRQ in partnership with the American Medical Association (AMA) and the American Association of Health Plans (AHIP).

<sup>32</sup> Thorpe (2007), "Potential Savings Under the AdvaMed Plan Associated with Health Reforms Focusing on Chronic Care Management, Prevention and Health Information Technology" found at: <http://www.advamed.org/NR/rdonlyres/03AE0ADD-3472-4F29-BC58-32EC0575AB67/0/healthreformsavingsthorpeFINAL.pdf>.

**Figure B-18**  
**Savings from an Institute for Comparative Effectiveness under the Obama Proposal**  
**(billions)**

Year	Spending on Chronic Conditions <sup>a/</sup>	Share of Chronic Care where Appropriate Care is Identified under Current Law	Share of Chronic Care where Appropriate Care is Identified under Proposal	Savings from Chronic Disease under Proposal	Cost of Comparative Effectiveness Program <sup>b/</sup>	Net Savings of Program Cost
2010	\$1,151.8	32.2%	33.4%	-\$0.2	\$0.9	-\$1.1
2011	\$1,230.1	34.6%	37.0%	\$0.5	\$0.9	-\$0.4
2012	\$1,316.2	37.0%	40.5%	\$1.4	\$1.0	\$0.4
2013	\$1,408.3	39.4%	44.0%	\$2.4	\$1.1	\$1.3
2014	\$1,505.5	41.8%	47.5%	\$3.6	\$1.1	\$2.5
2015	\$1,607.9	44.2%	51.0%	\$5.0	\$1.2	\$3.8
2016	\$1,717.2	46.6%	54.5%	\$6.7	\$1.3	\$5.4
2017	\$1,834.0	49.0%	58.0%	\$8.6	\$1.4	\$7.2
2018	\$1,958.9	51.4%	61.5%	\$10.7	\$1.5	\$9.2
2019	\$2,092.2	53.8%	65.0%	\$13.3	\$1.7	\$11.6
2010-2014	\$6,611.9	N/A	N/A	\$7.7	\$5.0	\$2.7
2010-2019	\$15,822.1	N/A	N/A	\$52.0	\$12.1	\$39.9

a/ Based on the assumption that 75 percent of total expenditures for personal care are attributed to chronic conditions. Estimates exclude care already covered under existing patient decision aid systems for patient preference sensitive care. Spending was increased based on spending projections.

b/ Reflects the savings achieved from translation of the guidelines findings into practice, (net of the costs of the institute in conducting review and research. Developed by the Office of the Actuary (OAct) of the Center for Medicare and Medicaid Services (CMS)).

Source: The Lewin Group estimates.

*Figure B-19* presents our estimates of the distribution of savings/costs by payer group.

#### **4. Increasing Savings**

The effectiveness of this proposal could be much greater if it were implemented with financial incentives for physicians and patients to comply with guidelines. Adherence to existing guidelines has been shown to be very low. To increase adherence, payers could deny or reduce reimbursement to physicians and hospitals when a high-cost intervention is performed when a lower cost treatment is available that has been shown to be at least as effective. In these cases, co-payments also could be increased for patients as further inducement for compliance with effective, lower-cost care. In a prior study, we estimated savings of up to \$368 billion over 10

years could be realized under a comparative effectiveness program if it were coupled with these financial incentives.<sup>33</sup>

**Figure B-19**  
Net Savings from the Institute for Comparative Effectiveness by Payer Group  
(billions)

Year	Household Out-of-Pocket and Premiums	Private Employer Savings	Federal Government Savings	State and Local Government Savings	Net Change in National Health Spending
2010	-\$0.3	-\$0.1	-\$0.7	\$0.0	-\$1.1
2011	-\$0.2	\$0.1	-\$0.4	\$0.1	-\$0.4
2012	\$0.0	\$0.4	-\$0.2	\$0.2	\$0.4
2013	\$0.2	\$0.6	\$0.2	\$0.3	\$1.3
2014	\$0.4	\$1.0	\$0.6	\$0.5	\$2.5
2015	\$0.7	\$1.3	\$1.1	\$0.7	\$3.8
2016	\$1.0	\$1.7	\$1.7	\$0.9	\$5.4
2017	\$1.4	\$2.2	\$2.4	\$1.2	\$7.2
2018	\$1.9	\$2.8	\$3.1	\$1.5	\$9.3
2019	\$2.4	\$3.5	\$4.0	\$1.8	\$11.7
2010-2014	\$0.1	\$2.0	-\$0.5	\$1.1	\$2.7
2010-2019	\$7.4	\$13.6	\$11.8	\$7.1	\$39.9

Source: The Lewin Group estimates.

## G. Promote Health Information Technology

The Obama proposal would provide \$50.0 billion in funding over five years to assist providers and state governments in implementing Health Information Technology (HIT). HIT includes a variety of integrated data sources, including patient Electronic Medical Records (EMR), Clinical Decision Support (CDS) Systems, and Computerized Physician Order Entry (CPOE) for medications and other medical services. HIT systems would improve access to patient information and allow health information to be communicated to other providers, patients, and insurers more efficiently. Literature suggests that the implementation of HIT would generate efficiency savings for providers and insurers while reducing the risk of medical errors.

In this study, we estimate the savings that would result from establishing a federal program to assist providers to invest in HIT. We begin by summarizing the available evidence on HIT cost savings. We then estimate savings under this illustrative program.

<sup>33</sup> Cathy Schoen et al., "Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending," The Commonwealth Fund, December 2007.

## 1. Background

The President's Information Technology Advisory Committee (PITAC) has recommended federal leadership in developing HIT systems centering on the development of computer-based patient data.<sup>34</sup> HIT systems center around computerized systems for recording patient medical histories, test results, and prescriptions called an electronic medical record (EMR).<sup>35</sup> The EMR would feature standardized terminology and reporting formats that eliminate the dangers arising from illegible handwriting and missing patient data. PITAC identified four essential elements of the HIT systems envisioned:<sup>36</sup>

- EMRs for all Americans that provide every patient and his or her caregivers all necessary information required for optimal care while reducing costs and administrative overhead.
- Computer-assisted clinical decision support (CDS) to increase the ability of health care providers to take advantage of state-of-the-art medical knowledge as they make treatment decisions (evidence-based medicine).
- Computerized practitioner order entry (CPOE) systems for tests, medicine, and procedures for outpatient care and care within the hospital environment;<sup>37</sup> this information, together with test results, would be recorded as a component of the EMR.
- Secure, private, interoperable, electronic health information exchange, including both highly specific standards for capturing new data and tools for capturing non-standards compliant electronic information from legacy systems.

The literature provides evidence of the potential cost impacts of such systems. Perhaps the best known of these articles is a study by Federico Girosi et al. of RAND, Inc. that estimates the potential savings from HIT to be about \$80.9 billion per year (in 2005 dollars) if fully implemented throughout the health care system.<sup>38</sup> *Figure B-20* presents Girosi's estimates of potential savings from HIT by functional area including transcription, chart pulls, laboratory tests, and improvements in efficiency for limited nursing staff.

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<sup>34</sup> President's Information Technology Advisory Committee. (2004, June). Report to the President: Revolutionizing Health Care Through Information Technology.

<sup>35</sup> Brailer, in his discussion of computer-based patient records focuses on the lack of commonly accepted and discrete definitions and terminology that have resulted in some confusion and slowed the progress of technology adoption. The terms he listed to give perspective on the problem are: automated medical record (AMR), clinical data repository (CDR), computer-based patient record (CPR), computer-based patient record system (CPRS), computerized medical record (CMR), electronic health record (EHR), electronic medical record (EMR), lifetime data repository (LDR), virtual health record (VHR) and virtual patient record (VPR). This list does not include the various terminologies for computer physician order entry or electronic prescribing programs.

<sup>36</sup> Advanced HIT systems also could facilitate the compilation for outcomes analyses and health quality measures that provide continual feedback to providers on the effectiveness of the care provided.

<sup>37</sup> CPOE also is recognized as computerized provider and/or physician order entry systems.

<sup>38</sup> Federico Girosi et al., *Extrapolating Evidence of Health Information Technology Savings and Costs*, Santa Monica, California: RAND Corporation, MG-410-HLTH, 2005.

Figure B-20  
Giroi Estimates of HIT-Enabled Savings over 15-year Adoption Period  
(billions)

Source of Savings	Potential Savings	Savings in 5 <sup>th</sup> Year of Adoption Period	Savings in 10 <sup>th</sup> Year of Adoption Period	Savings in 15 <sup>th</sup> Year of Adoption Period
<b>Outpatient Savings</b>				
Transcription	\$1.9	\$0.4	\$1.2	\$1.7
Chart Pulls	\$1.7	\$0.4	\$1.1	\$1.5
Laboratory Tests	\$2.2	\$0.5	\$1.5	\$2.0
Drug Utilization	\$12.9	\$3.0	\$8.6	\$11.8
Radiology	\$3.6	\$0.8	\$2.4	\$3.3
<b>Total</b>	<b>\$22.3</b>	<b>\$5.2</b>	<b>\$14.8</b>	<b>\$20.4</b>
<b>Inpatient Savings</b>				
Nurse Shortage	\$12.7	\$3.4	\$10.0	\$13.7
Laboratory Tests	\$3.0	\$0.8	\$2.2	\$2.8
Drug Utilization	\$3.7	\$1.0	\$2.8	\$3.5
Length of Stay	\$36.7	\$10.1	\$27.6	\$34.7
Medical Records	\$2.5	\$0.7	\$1.9	\$2.4
<b>Total</b>	<b>\$58.6</b>	<b>\$16.1</b>	<b>\$44.5</b>	<b>\$57.1</b>
<b>Combined Total</b>				
<b>Total</b>	<b>\$80.9</b>	<b>\$21.3</b>	<b>\$59.2</b>	<b>\$77.4</b>

Source: Federico Giroi et al., "Extrapolating Evidence of Health Information Technology Savings and Costs," Santa Monica, California: RAND Corporation, MG-410-HLTH, 2005.

The authors assume that this technology would be adopted by the industry over a period of 15 years. This is based on studies of the amount of time it has taken for other information technologies to be adopted. These data indicate that adoption tends to level off at about 90 percent after the 15<sup>th</sup> year.

They estimate that savings would reach \$21.8 billion in the fifth year of the adoption period, which we assume will be in 2010. Savings rise to \$59.2 billion in the tenth year and \$77.4 billion by the 15<sup>th</sup> year (*Figure B-20*).

It is important to understand that the authors are projecting that most of these savings will materialize over the next 15 years regardless of any change in public policy – these savings are already reflected in the current law "baseline" estimates of health spending over the next 15 years. Thus, the government may only accelerate the adoption of HIT.

It is also important to recognize that the Giroi estimates are of potential savings rather than realizable savings. They used in their work only those studies that showed savings while excluding those that did not show savings. This was intended to show potential savings if the

use of these systems could be optimized by all potential users. However, because the effectiveness of any new technology will be uneven across users, the savings that we can expect to realize from these systems is less than the \$80.9 billion in potential savings estimated by Girosi.

Other studies are available on the cost impacts of CPOE and CDS systems, but there is little evidence of savings from the detailed EMR itself. Savings from CPOE have been documented in both inpatient and ambulatory care settings. There is also growing evidence that CPOE and other elements of these technology advances would help avoid medical errors and reduce unnecessary duplication of tests in hospitals, resulting in reduced health spending. Studies indicate savings of between \$5.0 million and \$26.0 million for individual hospitals adopting elements of these HIT systems.<sup>39</sup>

A study by Bates found that CPOE for tests and prescriptions reduced non-intercepted serious medication errors by 55.0 percent, with a reduction in hospital charges of about 12.7 percent. Another study showed that a CPOE program assisting with antibiotic management resulted in a fivefold decrease in the frequency of excess drug dosages and a tenfold decrease in antibiotic-susceptibility mismatches, resulting in reduced health care costs.

Savings also are likely to result from automated systems in ambulatory care settings, such as physician offices. A study of 59 physician practices documented savings and increased revenues of about \$1.0 million compared with the prior year.<sup>40</sup> Savings in physician offices resulted from reduced need for transcription services, decreased labor and supply costs for chart maintenance and creation, and decreased physical space requirements due to the use of a paperless record. For example, it has been estimated that each physician request for a patient's medical record, called a "chart pull," can cost between \$8 and \$9 in labor and other costs. This study showed that the number of chart pulls requested declined by about 40 percent.<sup>41</sup>

## 2. Savings from Provider HIT

Our approach was to estimate the savings resulting from HIT under existing levels of investment and with the additional funding that would be provided under the program. Our estimate of the savings from provider HIT under the proposal is equal to the difference between projected savings under current law and projected savings under the proposed increase in funding. Savings would be based on the estimates of potential savings developed by Girosi, which we have adjusted downward by 15 percent to reflect our assumption that not all of these potential savings will actually be realized under the proposal.

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<sup>39</sup> Bates, D., Teich, J., Lee, J., et al. (1999). "The Impact of Computerized Physician Order Entry on Medication Error Prevention." *Journal of the American Medical Informatics Association*, 6, 313-21.

<sup>40</sup> Barlow, S., Johnson, J., and Steck, J. (2004). "The Economic Effect of Implementing an EMR in an Outpatient Setting." *Journal of Healthcare Information Management*, 18(1), 46-51.

<sup>41</sup> Johnston, D. (2003). "The Value of Computerized Provider Order Entry in Ambulatory Settings." Boston: Center for Information Technology Leadership. The study estimates that another \$27 billion could be saved through increased compliance with drug formularies (e.g., increased use of generic drugs), although these potential savings have yet to be demonstrated.



Bower (2005) developed an estimate of the trend in the percentage of providers that are adopting HIT under current policy. Girosi et al. (2005) used the Bower trend to model the accumulated costs and savings of HIT implementation over a 5, 10, and 15 year period. We used these estimates as the basis for estimating investment and cost savings over the 2010 through 2019 period. Based on the experience of IT adoption in other industries, Bower (2005) fitted the historical growth rate to estimate growth in HIT adoption for 2004 and latter years.

Bower found that IT diffusion in other industries tends to reach a maximum participation of 90 percent due to interoperability and connectivity limitations, which he included in his projections. Bower defined a provider as implementing HIT if the provider had deployed an electronic medical record system, clinical decision support, and Computerized Practitioner Order Entry (CPOE) systems.

The Girosi estimates do not include savings resulting from Health Information Exchange Networks (HIEN) and interoperability. HIEN permits direct access to individual patient EMRs by multiple providers. Because clinical tests and imaging results for each patient are stored in the EMR, this will enable providers to use recent tests and diagnostic information rather than duplicating these tests. This will improve disease and chronic care management in cases where individual patients are seeing multiple specialists. These systems would also enable emergency care providers to access complete medical history data for each patient.

Bigelow (2005) estimated short term savings of \$28.0 billion annually and long term savings of \$138.7 billion at 100 percent adoption and participation.<sup>42</sup> In this analysis, we assume that potential savings from such systems would be \$28.0 billion. We added this to the potential savings from HIT estimated by Girosi (\$80.9 billion) to obtain a maximum potential savings estimate of \$108.9 billion in 2005 dollars.

In this analysis, we assumed that 25 percent of the federal funding for HIT would go to state governments to fund development of HIEN systems. We estimate the savings/costs to national health spending associated with direct assistance to providers for HIT adoption by assuming an elasticity of -0.5 for acceleration in the rate of provider participation resulting from the government spending.<sup>43</sup> Under the proposal, we estimate provider participation reaches 90.0 percent in 2017. We estimate a net reduction in health spending of \$88.2 billion due to the funding for provider HIT over the 2010 through 2019 period (*Figure B-21*).

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<sup>42</sup> J. Bigelow et al., "Analysis of Healthcare Interventions that change Patient Trajectories (Santa Monica, Calif.: Rand, 2005), 137, Table 6.17.

<sup>43</sup> See note 12. Federico performed a sensitivity analysis on the adoption rate based on elasticity of -.25, -.5, and -.75.

Figure B-21  
Effects of Direct Assistance to Providers for HIT Adoption on National Health  
Expenditures under Obama Proposal  
(billions)

Year	HIT Adoption and Savings under Current Law				HIT Adoption and Savings under the Obama Proposal					Net Savings from Federal HIT Investment
	Percent Adoption <sup>a/</sup>	Annual Private Investment	Savings from HIT	Net Savings	Percent Adoption <sup>b/</sup>	Annual Private Investment	Public Investment	Savings from HIT	Net Savings	
2010	26.3%	\$6.2	\$34.5	\$28.3	31.1%	\$6.2	\$10.0	\$40.8	\$24.6	-\$3.8
2011	33.9%	\$11.1	\$47.4	\$36.3	42.1%	\$11.1	\$10.0	\$58.8	\$37.7	\$1.4
2012	43.9%	\$11.1	\$65.3	\$54.2	56.6%	\$11.1	\$10.0	\$84.1	\$63.0	\$8.9
2013	56.7%	\$11.1	\$89.7	\$78.6	75.2%	\$11.1	\$10.0	\$118.9	\$97.8	\$19.2
2014	73.2%	\$11.1	\$123.2	\$112.1	90.0%	\$11.1	\$10.0	\$151.5	\$130.4	\$18.3
2015	76.3%	\$11.1	\$136.6	\$125.5	90.0%	\$11.1	\$0.0	\$161.2	\$150.1	\$24.5
2016	79.6%	\$5.5	\$151.7	\$146.2	90.0%	\$5.5	\$0.0	\$171.5	\$166.0	\$19.8
2017	82.9%	\$5.5	\$168.1	\$162.6	90.0%	\$5.5	\$0.0	\$182.5	\$177.0	\$14.4
2018	86.4%	\$5.5	\$186.4	\$180.9	90.0%	\$5.5	\$0.0	\$194.2	\$188.7	\$7.8
2019	90.0%	\$5.5	\$206.6	\$201.1	90.0%	\$5.5	\$0.0	\$206.6	\$201.1	\$0.0
<b>2010-14</b>	N/A	\$50.6	\$360.1	\$309.5	N/A	\$50.6	\$50.0	\$454.1	\$353.5	\$44.0
<b>2010-19</b>	N/A	\$83.7	\$1,209.4	\$1,125.7	N/A	\$83.7	\$50.0	\$1,370.0	\$1,236.3	\$110.5

a/Extrapolated from 5, 10, and 15 year projections of savings and costs found in Federico, G., Extrapolating Evidence of Health Information Technology Savings and Costs, Santa Monica, California: RAND Corporation, MG-410-HLTH, 2005.

b/ Increased by extrapolating the effects of using an elasticity of -0.5 on the 5, 10, and 15 year projections of savings and costs found in Federico, G., "Extrapolating Evidence of Health Information Technology Savings and Costs," Santa Monica, California.: RAND Corporation, MG-410-HLTH, 2005. Baseline costs for HIEN implementation extrapolated from: Kausal, R. "The Costs of a National Health Information Network", *Annals of Internal Medicine*, 2005.

Source: The Lewin Group estimates.



### 3. Program Savings

Figure B-22 presents our estimates of the savings in national health spending attributed to the HIT provisions of the Obama plan by major payer group due to accelerated adoption of HIT.

**Figure B-22**  
Savings in National Health Spending due to the Health Information Technology Provisions of the Obama Proposal by Payer Group  
(billions)

Year	Household Out-of-Pocket and Premiums	Private Employer Savings	Federal Government Savings	State and Local Government Savings	Net Change in National Health Spending
2010	\$1.6	\$1.3	-\$7.8	\$1.1	-\$3.8
2011	\$2.9	\$2.3	-\$5.9	\$2.1	\$1.4
2012	\$4.8	\$3.8	-\$3.2	\$3.5	\$8.9
2013	\$7.5	\$5.9	\$0.4	\$5.4	\$19.2
2014	\$7.3	\$5.7	\$0.1	\$5.2	\$18.3
2015	\$6.3	\$5.0	\$8.8	\$4.5	\$24.5
2016	\$5.1	\$4.0	\$7.1	\$3.6	\$19.8
2017	\$3.7	\$2.9	\$5.2	\$2.6	\$14.4
2018	\$2.0	\$1.6	\$2.8	\$1.4	\$7.8
2019	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
2010-2014	\$24.1	\$19.0	-\$16.3	\$17.2	\$44.0
2010-2019	\$65.3	\$32.5	\$7.5	\$29.4	\$110.5

Source: The Lewin Group estimates.

### H. Chronic Disease Management (DM)

The Obama plan would support disease management and other efforts to coordinate and integrate care for the chronically ill. It is estimated that about 75 percent of all health care costs are attributed to people with chronic diseases such as diabetes, heart disease and high blood pressure. However, Thorpe (2007) has estimated that 56 percent of the chronically ill are not receiving the appropriate preventative services.<sup>44</sup> Consistent with Thorpe's finding, Thier et al. (2008) found that adherence to evidence-based medicine averaged about 59 percent among the chronically ill.<sup>45</sup>

<sup>44</sup> Thorpe (2007), "Potential Savings Under the AdvaMed Plan Associated with Health Reforms Focusing on Chronic Care Management, Prevention and Health Information Technology" found at: <http://www.advamed.org/NR/rdonlyres/03AE0ADD-3472-4F29-BC58-32EC0575AB67/0/healthreformsavingsthorpeFINAL.pdf>

<sup>45</sup> Their, et al., "In Chronic Disease, Nationwide Data Show Poor Adherence by Patients to Medication and by Physicians to Guidelines," *Managed Care*, February 2008.

The Obama plan states that it would address these needs by requiring “that plans that participate in the new public plan, Medicare or the Federal Employees Health Benefits Program (FEHBP) utilize proven disease management programs.” We estimated the impact of these provisions on health expenditures separately for Medicare and the non-Medicare population enrolling in the exchange.

### *1. Cost Impacts of Chronic Disease Management*

Disease management includes a range of programs to assure that chronic care patients receive required preventive care to avoid medical complications. Chronic DM typically serves to ensure that clinical practice guidelines are implemented. It is also used to coordinate care for patients receiving care for the disease from many different physicians.

The available literature describes a current nationwide trend among private health plans to adopt disease management programs. This trend is expected to continue for the foreseeable future, even in the absence of new legislation. This is because disease management is widely perceived to improve quality while reducing costs for at least some chronic conditions. These programs also appear to be popular among both physicians and beneficiaries, which would tend to limit resistance to adopting these approaches.<sup>46</sup>

While these programs can help avoid medical complications with preventive care, these cost savings can be more than offset by the cost of providing preventive services and medications. In fact, the Thorpe analysis implies that about 56 percent of all people with chronic conditions would receive services they are not already using, which will largely offset the savings from avoidable complications.

The RAND Corporation recently released a study in which they performed a review of “evaluations, systematic reviews and meta-analyses covering 317 unique studies.”<sup>47</sup> The review found consistent evidence that these programs can improve health care quality, and disease control. They also found evidence that these chronic DM programs reduced hospital utilization for people with congestive heart failure. However, they also found evidence that patients with depression were more likely to use outpatient care and prescription drugs.

In October of 2004, the Congressional Budget Office (CBO) released its own review of the literature on the potential cost savings from chronic DM programs stating that:

“On the basis of its examination of peer-reviewed studies of disease management programs for congestive heart failure (CHF), coronary artery disease (CAD), and diabetes and the conclusions reached by other reviews of the relevant literature published in major medical journals, CBO finds that to date there is insufficient

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<sup>46</sup> Felt-Lisk S., and Mays G., “Back to the Drawing Board: New Directions in Health Plans’ Care Management Strategies,” *Health Affairs*, 21(5): 210-217.

<sup>47</sup> RAND Corporation “Disease Management Programs May Improve Quality of Care, But May Not Save Money,” News Release, December 10, 2007.

evidence to conclude that disease management programs can generally reduce the overall cost of health care services.”<sup>48</sup>

The chief limitation of the existing research is that few of these studies actually address the question of cost savings. While some studies have shown savings from chronic DM for certain health conditions, these studies have also been criticized for flawed methods and the lack of randomized control trial (RCT) studies measuring the impact of these programs.<sup>49,50</sup> The CBO analysis concluded that the few studies reporting cost savings generally do not account for all health care costs such as the cost of the intervention.

Chronic DM appears to be most successful in terms of cost savings in programs for diabetes, heart disease and lung disease. While a study by the America’s Health Insurance Plans (AHIP) recently suggested the savings from disease management programs range from 6 percent to 33 percent, other studies report limited impact on use of health care services.<sup>51,52</sup> Standards for evaluating the evidence in chronic DM programs currently are being developed in association with the Disease Management Association of America.

## 2. Disease Management in Public Programs

Chronic conditions are a leading cause of illness, disability, and death among Medicare beneficiaries and account for a disproportionate share of health care expenditures according to the Center for Medicare and Medicaid Services (CMS). About 14 percent of Medicare beneficiaries have heart failure, but they account for 43 percent of Medicare spending. About 18 percent of Medicare beneficiaries have diabetes, yet they account for 32 percent of Medicare spending.<sup>53</sup> The rate of chronic illness is even higher among Medicaid beneficiaries; about 14.4 million (30 percent) of Medicaid beneficiaries have a chronic illness.<sup>54</sup>

Medicare is conducting a demonstration of a disease management program for Medicare beneficiaries called The Medicare Chronic Care Improvement Program (CCIP), which was established under the Medicare Modernization Act. Under this program CMS selected nine chronic care improvement programs for award, eight of which were initiated between August

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<sup>48</sup> Letter to the Honorable Don Nickles, from Douglas Holtz-Eakin, October 13, 2004.

<sup>49</sup> For example, over 90% of people enrolled in a six month diabetes management program reported that they were satisfied with the care received. See Felt-Lisk S., and Mayes G., “Back to the Drawing Board: ‘New Directions in Health Plans’ Care Management Strategies,” *Health Affairs*, 2002, 21(5): 210-217; and Rubin R. et. al, “Clinical and Economic Impact of Implementing a Comprehensive Disease Management Program in Managed Care,” *Journal of Clinical Endocrinology and Metabolism*, 83(8):2635-2642.

<sup>50</sup> Fetterolf D., MD, Wennberg D., MD and DeVries A., “Estimating the Return on Investment in Disease Management Programs Using A Pre-Post Analysis,” July 31, 2003; and Fitzner K., et al., “Principles for Assessing Disease Management Outcomes,” Disease Management Association.

<sup>51</sup> American Association of Health Plans/Health Insurance Association of America (November 2003). *The Cost Savings of Disease Management Programs: Report on a Study of Health Plans*.

<sup>52</sup> Center on an Aging Society, Georgetown University (2004 January). Issue Brief Number 4: *Disease Management Programs: Improving Health While Reducing Costs?* retrieved August 2004.

<sup>53</sup> [www.cms.hhs.gov](http://www.cms.hhs.gov).

<sup>54</sup> “Designing and Implementing Medicaid Disease and Care Management Programs: A User’s Guide,” prepared by The Lewin Group for the Agency for Healthcare Research and Quality (AHRQ), available at [www.ahrq.gov/qual/medicaidmgmt/#Ack](http://www.ahrq.gov/qual/medicaidmgmt/#Ack).

1, 2005, and January 16, 2006. The first phase of the project focuses on Medicare beneficiaries with congestive heart failure, complex diabetes or chronic obstructive pulmonary disease. Doctors who meet performance standards set by CMS receive bonus payments for managing care for the beneficiaries.

A preliminary evaluation was conducted of the first six months of program implementation, and a report was published in June 2007.<sup>55</sup> Key findings include:

- **Healthier beneficiaries participating in CCIP:** Medicare Health Support Organizations (MHSOs) appear to be engaging significantly healthy beneficiaries. These beneficiaries tend to be significantly healthier and have lower rates of co-morbid conditions. Beneficiaries who are also eligible for Medicaid (i.e., dual eligibles) or those that are more costly appear to not be participating.
- **Beneficiaries are overall satisfied with providers:** Approximately 80 percent of beneficiaries in each of the eight CCIP participating MHSOs rated their experience with health care providers as good, very good, or excellent.
- **Medicare payments tend to be higher in the intervention than in the comparison group:** In Phase I of the pilot, each MHSO receives a negotiated monthly administrative fee per participant, contingent on improvements in quality, and beneficiary and provider satisfaction, and 5 percent savings on Medicare net payments of management fees at the end of the three-year pilot.

Overall, disease management fees have not been recovered through reductions in Medicare spending. Thus the pilot does not satisfy budget neutrality and is far from meeting an anticipated 5 percent savings in Medicare payments. However, it has not been determined whether savings could be improved if the group were more representative of the population.

About half of the states have implemented or are implementing disease management programs in Medicaid, reflecting that 83 percent of spending is dedicated to people with multiple chronic conditions.<sup>56</sup> Under current policy, Medicaid expenditures for disease management are eligible for federal matching dollars.<sup>57</sup> States may either create their own program or contract with a disease management organization to administer the program. Although there is little research on the impact of these programs, there is evidence of improved outcomes and some limited savings. Disease management under the Medicaid program is expected to continue to grow under current law.<sup>58</sup>

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<sup>55</sup> N. McCall, Sc.D., J. Cromwell, Ph.D., S. Bernard, Ph.D., "Evaluation of Phase I of Medicare Health Support (Formerly Voluntary Chronic Care Improvement) Pilot Program Under Traditional Fee-for-Service Medicare," RTI International, Report to Congress, June 2007.

<sup>56</sup> Ibid.

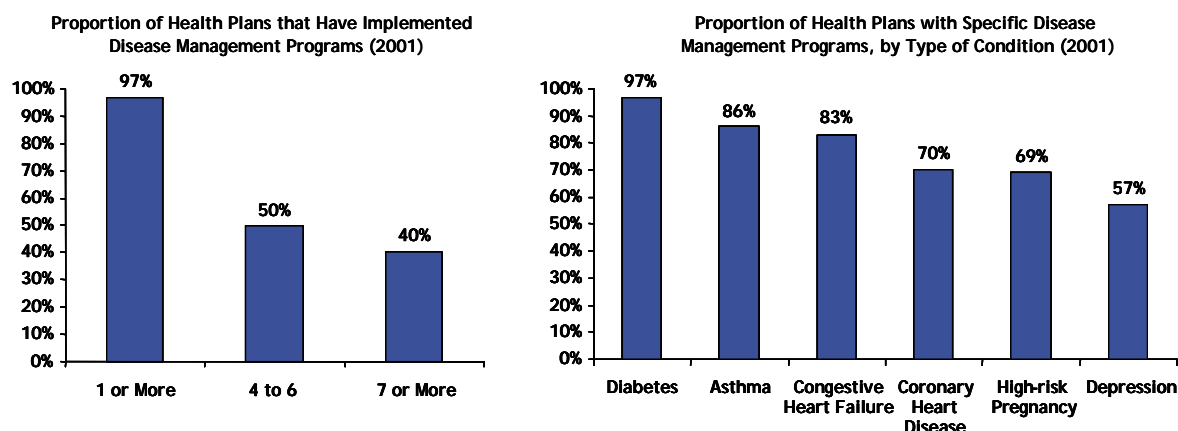
<sup>57</sup> Center for Medicare & Medicaid Services, "CMS Urges States to Adopt Disease Management Programs, Agency Will Match State Costs" *Medicaid News*, press release (2004 February 26) retrieved in August 2004 from <http://www.cms.hhs.gov/pf/printpage.asp?ref=http://63.241.27.79/media/press/release.asp>.

<sup>58</sup> National Governors Association (NGA). Center for Best Practices (2003).

### 3. Disease Management in Private Insurance

Many private payers and employers already have adopted disease management programs. A survey of health plans in 2002 indicates that about 97 percent of health plans already have a disease management program for at least one chronic condition and about half have programs for two or more conditions (*Figure B-23*). About 97 percent of health plans indicated they have some form of disease management program for diabetes, 83 percent reported a program for congestive heart failure and 70 percent reported a program for coronary heart disease.<sup>59</sup>

Figure B-23  
Disease Management Programs by Health Plans and Type of Condition



Source: As retrieved from the Center on an Aging Society, Georgetown University (January 2004). Issue Brief Number 4: Disease Management Programs: Improving health while reducing costs? Originally cited by the American Association of Health Insurance Plans, Industry Survey, 2002.

The use of chronic DM programs has likely increased in recent years and is likely to continue to increase under current trends, even in the absence of the Obama plan. Thus, even if chronic DM does reduce costs, most of the private sector savings from disease management are in the “baseline” spending numbers for private health plans over the next 10 years.

### 4. Estimated Cost Impacts of Obama Plan

Estimating potential savings from disease management is made difficult by the lack of conclusive research. The limited research on the cost effects of chronic DM does not provide a clear indication of whether cost savings will exceed the cost of the intervention and the cost of adherence to guidelines, such as increased use of prescription drugs. However, just as we can not conclude from the research that there will be savings from chronic DM, we also can not conclude from the research that chronic DM will not result in savings.

For illustrative purposes, we estimate the likely savings from the Obama chronic DM provisions based upon what little is known. The strongest evidence of chronic DM savings is for diabetes

<sup>59</sup> American Association of Health Plans (2002) *Highlights of the 2001 AAHP Annual Industry Survey* as cited in Issue Brief Number 4: “Disease Management Programs: Improving health while reducing costs?,” retrieved from: Center on an Aging Society’s Issue Brief Number 4 (January 2004).

and heart disease. Consequently, we assume that savings will be realized for only patients with these conditions.

Based upon an analysis of the Medicare 5 percent sample of beneficiary claims, we assume that about 35 percent of the Medicare population has one or both of the health conditions that would apply.<sup>60</sup> We estimate that average health spending for this group is about \$13,332 in 2010. We assume that about 20 percent of the Medicare population is enrolled in a health plan under Medicare Advantage, where some form of disease management is already provided. Because the literature on clinical guidelines shows that many physicians and patients do not adhere to guidelines, we assume that the number of chronically ill people who are not receiving required services (currently estimated to be 56 percent) is reduced by two-thirds. We assume savings of 5 percent for these beneficiaries.

We use a similar approach for estimating chronic DM savings for the non-Medicare population. As discussed above, health plans serving people through the exchange would be required to adopt chronic DM. Also, because private plans often adopt payment and cost control methodologies developed in public plans, we assume that about 20 percent of private plans outside the exchange will adopt similar programs where they do not exist. Based upon the AHIP data presented above, we assume that 97 percent of the people with private insurance have a chronic DM program for diabetes and that about 75 percent already have a chronic DM plan for heart disease. Based upon analysis of MEPS data, we assume the following:

- **Diabetes:** We assume net savings of about 5 percent for privately insured people with diabetes. We estimate that about 2.5 percent of privately insured people have diabetes, with average health care costs of about \$6,753 per person in 2010.
- **Heart Disease:** We assume net savings of 5 percent for privately insured persons with heart disease. We estimate that about 11.4 percent of privately insured people have such conditions, with average health care costs of \$6,403 per person in 2010. These estimates are based upon Lewin analysis of the Medical Expenditures Panel Survey (MEPS) data updated to 2010 spending levels.<sup>61</sup>

As shown in *Figure B-24*, we estimate that this would reduce spending under Medicare by \$33.3 billion over the 2010 through 2019 period. Savings for those covered under the exchange and other private plans would be about \$7.6 billion over that 10-year period. These estimates assume that these savings will phase-in over the first three years of the program.

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<sup>60</sup> About 17.6% of Medicare enrollees have diabetes (about 56% of whom also have cardiac disease) and about 38% have some form of cardiovascular disease, not all of which would qualify under the program.

<sup>61</sup> These estimates are based upon Lewin analysis of the Medical Expenditures Panel Survey (MEPS) data updated to 2010 spending levels.



**Figure B-24**  
**Chronic Disease Management Savings under the Obama Plan: 2010 - 2019**  
**(billions)**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
<b>Savings to Medicare</b>											
Medicare	--	\$1.2	\$2.6	\$3.6	\$3.9	\$4.2	\$4.5	\$4.9	\$5.3	\$5.8	\$36.0
<b>Savings to Privately Insured</b>											
Non-Medicare in Exchange	--	\$0.3	\$0.6	\$0.8	\$0.8	\$0.9	\$0.9	\$1.0	\$1.1	\$1.2	\$7.6
<b>Total Disease Management Savings</b>											
Total Savings	--	\$1.5	\$3.2	\$4.4	\$4.7	\$5.1	\$5.4	\$5.9	\$6.4	\$7.0	\$43.6

Source: The Lewin Group estimates.

## I. Coordinate and Integrate Care (Medical Home)

The Obama proposal would promote the use of the “medical home” model to improve coordination of care and reduce health spending. Under this model, patients select a provider to be their medical home. The designated provider, usually a primary care physician, would then be responsible for coordinating the care provided to the patient by all health care providers. This is especially important for patients with several medical conditions treated by different specialists.

Over half of people with serious chronic conditions are receiving care from three or more physicians.<sup>62</sup> This can result in duplicate tests, conflicting medical advice and prescriptions for contraindicated medications. The medical home provider would take responsibility for coordinating this care and would often be able to deliver care that otherwise would have been provided at greater cost by a specialist. In addition, medical home providers are responsible for hospital admissions and obtaining prior authorization for elective inpatient and outpatient procedures.

### 1. Background

The medical home model is designed to reduce costs by encouraging people to obtain primary and preventive care. Also, primary care physicians and nurse practitioners typically have lower charges than specialist physicians and typically use fewer expensive diagnostic services. Thus, the emphasis on primary care is likely to reduce costs.

Medicaid programs have experienced both improved health outcomes and cost savings through Primary Care Case Management programs (PCCM), which emphasize coordinated care provided through a primary care physician.<sup>63</sup> Currently, 26 percent of Medicaid enrollees

<sup>62</sup> Gerald Anderson et al., “Chronic Conditions: Making the Case For Ongoing Care,” 2004, Partnership for Solutions, (Johns Hopkins and Robert Wood Johnson Foundation (RWJF)).

<sup>63</sup> Cotter JJ, McDonald KA, Parker DA, et al. Effect of different types of Medicaid managed care on childhood immunization rates. *Eval Health Prof.* Dec 2000;23(4):397-408. Rossiter, LF, Whitehurst-Cook MY, Small RE, et al. The impact of disease management on outcomes and cost of care: a study of low-income asthma patients. *Inquiry.* Summer 2000;37(2):188-202. Silberman P, Poley S, Slifkin R. Innovative Primary Care Case Management Programs Operating in Rural Communities: Case Studies of Three States.

participate in PCCM.<sup>64</sup> Evidence shows that as the role of the primary care physician in the delivery of medical care increases, health outcomes improve and costs decline.<sup>65</sup> The experience in the Medicaid program of strengthening the role of the primary care physician has shown significant cost savings.<sup>66</sup>

Medicare currently has some limited experience with PCCM. In 2001, CMS implemented a demonstration to enroll certain chronically ill beneficiaries in coordinated care programs that shared many of the features of PCCM.<sup>67</sup> In 2002, Medicare began the Medicare Coordinated Care Demonstration (MCCD). This demonstration created medical homes for a sample of chronically ill Medicare beneficiaries. In the 2004 evaluation of the demonstration, Mathematica reported preliminary findings.<sup>68</sup> Although they had no analysis on costs, they did report physician survey results that showed participating physicians had difficulty in meeting enrollment targets. They also showed that after one year under coordinated care, physicians and enrollees were happy with the program.

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 experience of major HMOs provides examples of how increased reliance on primary care can affect costs. These types of integrated delivery systems typically emphasize primary care as a means of controlling access to specialists and reducing unnecessary tests, resulting in an overall reduction in utilization. Although the available evidence indicates that managed care plans achieve lower costs largely through selective contracting (i.e., volume price discounts), utilization of health services is typically lower than in other types of plans. For example, one study showed that health services utilization in IPA HMOs is about four percent lower than in other types of health plans (there were additional savings from selective contracting).<sup>69</sup>

Private health plans report that they have had success in reducing costs with medical home models in more traditional FFS plans. Blue Cross and Blue Shield of Minnesota (BCBSMN) implemented a program that uses predictive modeling to identify people with multiple chronic conditions who can be expected to require relatively high levels of medical care. These individuals are then asked to enroll in an expanded disease management program covering 17 chronic conditions, in which they would receive proactive interventions designed to prevent

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<sup>64</sup> Medicaid Enrollment in Comprehensive Managed Care Plans by Type.

<sup>65</sup> Starfield, B. (2005), "Contribution of Primary Care to Health Systems and Health," *The Milbank Quarterly*, Vol. 83, No. 3 2005 (p.-457-502).

<sup>66</sup> 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).

<sup>67</sup> Report found at: <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=263>

<sup>68</sup> Mathematica Policy Research, Inc. Report to Congress (2004). Coordinating Care for Medicare Beneficiaries of 15 Demonstration Programs, Their Patients, and Providers.

<sup>69</sup> The Lewin Group, "New Evidence on Savings from Network Models of Managed Care," (a report to the Healthcare Leadership Council), Washington DC, May 1994.



conditions from becoming acute. The use of predictive modeling allows plans to target management efforts to those most likely to have significant health utilization.<sup>70</sup>

BCBSMN reported a 95 percent participation rate with monthly gross savings of \$41 per participant.<sup>71</sup> After accounting for the cost of the intervention, the program resulted in savings of between 2 percent and 3 percent of the commercial health-care expenditure rate.

A recent article on the Geisinger Health System demonstrates the potential for innovation in providing medical home services through an integrated delivery system.<sup>72</sup> However, the capacity to manage a patient's care is diminished in traditional fee-for-service plans where physician and patient incentives to adhere to the medical home model are absent.<sup>73</sup> In addition, a survey of large medical practices indicates that many have little of the infrastructure required to apply all of the features of the medical home model.

## 2. Assumed Specification

The Obama plan omits important details on how the program would be implemented. For example, it does not indicate whether primary care physicians would receive payment for providing these additional services. It also does not specify whether use of the program would be mandatory or optional to the patient. In addition, the plan does not mention the use of penalties for seeing a specialist without referral from the primary care provider, as is usually used in "gatekeeper" models in private managed care plans.

These details of the plan are sure to be controversial, especially if applied in Medicare. Therefore, we assume that the plan is optional for both the provider and the beneficiary. We also assume no changes in provider payments of patient co-payments as inducements to cooperate with the medical home program.

Medicare patients with multiple chronic conditions would be identified and offered participation in the medical home program. As an inducement to enroll, beneficiaries would receive additional benefits such as 24-hour coverage, telephone/email consultation, care management and coordination, and patient education and counseling. However, there would be no penalties to the patient for accessing a specialist without referral.

Participants would choose a primary care physician who has agreed to participate in the program. For providing a medical home to beneficiaries, participating primary care physicians are paid traditional fee-for-service rates plus an additional per patient, monthly fee for enrolled beneficiaries of \$4.00 per month. There would be no penalty for a specialist who sees a patient without referral from the primary care provider.

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<sup>70</sup> Keckley, P. "The Medical Home: Disruptive Innovation for a New Primary Care Model," (report by the Deloitte Center for Health Solutions)

<sup>71</sup> Gold, W. & Kongstvedt, "How Broadening DM's Focus Helped Shrink One Plan's Costs," *Managed Care Magazine*, November 2003.

<sup>72</sup> Paulus, R., et al., "Continuous Innovation in Health Care: Implications of Geisinger Experience," *Health Affairs*, 2008, Vol. 27, number 5.

<sup>73</sup> Rittenhouse, D., et al., "Measuring the Medical Home Infrastructure in Large Medical Groups," *Health Affairs*, 2008, Vol. 27, number 5.

We also assume that the program would require all plans in the exchange to adopt a similar medical home model.

### 3. Program Impacts Estimates

Based upon the estimates provided by Anderson (2004), we assumed that 50 percent of Medicare spending is attributed to Medicare beneficiaries with multiple chronic conditions that would be eligible for the medical home model.<sup>74</sup> We assume that this group accounts for about 75 percent of Medicare spending. We assume that about half of these people would enter the program. This reflects the optional nature of the program to patients and physicians, as well as access constraints that may limit access to primary care. Based upon historical data on the growth in enrollment in the Medicare HMO program, now called Medicare Advantage, we assume that enrollment would phase-in over the first four years of the program.<sup>75</sup>

We estimated the savings from this approach based upon the Momany et al. estimates of savings when applied in Medicaid. As discussed above, Momany projected net savings that increased from 1.5 percent in 1991 to 9.8 percent in 1998. The average annual savings over the period of their estimates was 3.8 percent. To incorporate a \$4.00 rather than a \$2.00 payment rate to physicians in the Momany study, we reduced the net savings by 8 percent each year, resulting in an average savings estimate of 3.5 percent. However, because patients are permitted to access specialists without referral without penalty, we assume that the effectiveness of the program is reduced by about one-third to 2.5 percent.

Using these assumptions, we estimate savings to Medicare of \$96.3 billion over the 2010 through 2019 period (*Figure B-25*).

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<sup>74</sup> Ibid.

<sup>75</sup> CMS managed care enrollment reports at:  
[http://www.cms.hhs.gov/HealthPlanRepFileData/02\\_SC.asp#TopOfPage](http://www.cms.hhs.gov/HealthPlanRepFileData/02_SC.asp#TopOfPage).

**Figure B-25**  
**Projected Savings in Medicare Expenditures under Optional Medical Home Model**  
**(billions)**

Year	Projected Medicare Expenditures <sup>a/</sup>	Medicare Spending for Group Enrolled in Medical Home	Percent Savings under Medical Home Program	Medicare Program Savings
2010	\$545.60	\$27.3	0.8%	\$0.2
2011	\$602.00	\$90.3	1.5%	\$1.4
2012	\$610.30	\$183.1	2.2%	\$4.0
2013	\$680.20	\$380.9	2.5%	\$9.5
2014	\$739.70	\$414.2	2.5%	\$10.4
2015	\$805.80	\$451.2	2.5%	\$11.3
2016	\$907.30	\$508.1	2.5%	\$12.7
2017	\$1,024.80	\$573.9	2.5%	\$14.3
2018	\$1,111.90	\$622.7	2.5%	\$15.6
2019	\$1,206.40	\$675.6	2.5%	\$16.9
2010-2014	\$3,177.80	N/A	N/A	\$25.5
2010-2019	\$8,234.00	N/A	N/A	\$96.3

a/Medicare expenditure projections were taken from the Fact Sheet for CBO's March 2008 Baseline: Medicare.

Source: The Lewin Group estimates.

As discussed above, we also assumed that health plans participating in the exchange are required to offer the medical home model as a condition of participation. Also, because private plans often adopt payment and cost control methodologies developed in public plans, we assume that about 20 percent of private plans outside the exchange will adopt similar programs where they do not exist. We estimated the savings for the population in the exchange in proportion to savings under Medicare. We estimate savings for the non-Medicare population enrolling in the exchange of \$36.6 billion over the 2010 through 2019 period (*Figure B-26*). Total savings for Medicare and plans in the exchange would be \$132.8 billion over this period.

Figure B-26  
Medical Home Proposal Savings under the Obama Plan: 2010 - 2019  
(billions)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
Savings to Medicare											
Medicare	\$0.2	\$1.4	\$4.0	\$9.5	\$10.4	\$11.3	\$12.7	\$14.3	\$15.6	\$16.9	\$96.3
Savings to Privately Insured											
Non-Medicare in Exchange	\$0.1	\$0.5	\$1.5	\$3.6	\$3.9	\$4.3	\$4.8	\$5.5	\$5.9	\$6.4	\$36.6
Total Medical Home Savings											
Total Savings	\$0.3	\$1.9	\$5.6	\$13.1	\$14.3	\$15.6	\$17.5	\$19.8	\$21.5	\$23.3	\$132.8

Source: The Lewin Group estimates.

#### 4. Increasing the Savings from the Medical Home Model

As discussed above, we assume that the medical home model is offered as an option, with premium incentives and additional benefits as an inducement to enroll. Savings could be increased dramatically by making the medical home model mandatory for all of those participating in Medicare or the exchange. The effectiveness of the program also could be enhanced by introducing penalties for patients who access a specialist without referral, such as higher co-payments or even denial of payment for specialist services.

For example, in a prior study using a similar methodology, we estimated that Medicare could save up to \$206 billion over 10 years if this program were made mandatory with penalties for patients who see specialists without referral from their medical home provider. Thus, savings would be greater if all beneficiaries were required to participate in a program with financial incentives for patients to adhere to primary care management.

#### J. Incentives for Quality—Pay-For-Performance

The Obama proposal would begin to pay providers on the quality of health outcomes. Under such a system, data would be compiled for providers for patients receiving selected health services. The results would be adjusted for the severity of illness and compared with benchmark measures of outcomes for these services. Providers with favorable results would be rewarded with higher payments. This approach is known as “pay-for-performance” (P4P).

The Obama plan does not specify which providers and services would be subject to the system. It also does not specify the amount of the “reward” for good performance and does not indicate whether poorly performing providers would be penalized. For illustrative purposes, we specified a program based upon an ongoing Medicare demonstration project.

## 1. Assumed Specifications

For illustrative purposes, we assumed that the Obama plan will expand the CMS Premier Hospital Quality Incentive Demonstration (HQID) to apply to all acute care hospitals.<sup>76</sup> The purpose of the HQID demonstration was to promote quality improvement in acute care hospitals by expanding the public quality reporting system. This expansion included financial incentives for participating acute care hospitals that demonstrated higher quality in the acute care conditions listed above. The program applies to five conditions including:

- Acute myocardial infarction (AMI);
- Isolated coronary artery bypass graft (CABG);
- Heart failure (HF);
- Community acquired pneumonia (CAP); and
- Hip and knee replacement surgery (Hip/Knee).

In 2003 the CMS/Premier Hospital Quality Incentive Demonstration was initiated. The demonstration initially enrolled 276 hospitals to participate in the program. The demonstration developed quality scores for the five conditions discussed above and provided financial awards to participating hospitals for achieving certain quality thresholds. Hospitals performing at or above the 90<sup>th</sup> percentile received a 2 percent bonus in the clinical area. Hospitals performing at or above the 80<sup>th</sup> percentile received a one percent bonus. Hospitals performing at or below the 20<sup>th</sup> percentile received a one percent penalty. Hospitals performing in the bottom decile received a 2 percent penalty.

Lindenauer, et al (2007) showed overall improvement in the quality of the hospitals participating in the public reporting system.<sup>77</sup> The subset of hospitals receiving financial incentives showed slightly greater rates of improvement. Premier showed that for those hospitals receiving financial awards, the quality improvements resulted in savings derived from shorter lengths of stay and reduced re-admission rates.

We assume that under the Obama proposal, the demonstration would be expanded to all acute care hospitals. We also assumed that the financial award would be modified extending the bonus to hospitals in the 75<sup>th</sup> percentile and eliminating the payment penalty for hospitals in the bottom two deciles of the performance distribution. The policy would reward hospitals in the 90<sup>th</sup> percentile with a 2 percent bonus on their Medicare payment for the clinical area that showed improvement. Hospitals that achieve the 80<sup>th</sup> or 75<sup>th</sup> percentile depending on their prior year performance would receive a 1 percent bonus.

Eligibility for all bonuses relies on attaining a minimum level of performance in the two years prior to the payment year. Funding for the bonuses will be derived by reducing the total payment to all hospitals by the total projected bonus payments.

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<sup>76</sup> Premier is a nationwide association of not-for-profit hospitals.

<sup>77</sup> Lindenauer, P., "Public Reporting and Pay for Performance in Hospital Quality Improvement," *New England Journal of Medicine*, 356;5, February 1, 2007.

## 2. Methodology

We estimated the impact of the program based upon the Lindenauer evaluation of results from the demonstration and data provided by the Hospital Quality Alliance (HQA). The HQA was developed to provide public reporting of quality measures for acute care hospitals. It was formed in 2002 by the American Hospital Association (AHA), the Federation of American Hospitals, and the Association of American Colleges. All acute care hospitals were asked to participate in the program and HQA achieved a 98 percent participation rate.<sup>78</sup>

To establish the baseline quality scores for each hospital in each clinical area we used the HQA data archive. This database has the quality scores for each quality measure for Heart Failure, AMI, CAP, and surgical infection prevention (applied to Hip/Knee) for each hospital reporting to the HQA database. We created a composite quality score for each clinical area at a hospital by calculating the average score in each clinical area weighted by the number of patients treated for the measure. The baseline costs for each procedure were calculated using the 2005 Medicare Provider Analysis and Review (MEDPAR) file. We calculated the costs for each clinical area by summarizing the cost data using the HQID definitions for the conditions.<sup>79</sup>

To calculate the savings associated with the expansion of the demonstration, we used the findings in Lindenauer (2007) to estimate improvements in quality associated with the financial awards. Lindenauer found the annual improvement for AMI to be 2.5 percent, 3.0 percent for Heart Failure, and 2.3 percent for CAP. We used the rate of improvement for AMI as the rate of improvement for CABG. Since Lindenauer did not report an annual improvement for Hip/Knee we estimated an improvement rate as follows. We used the annual improvement reported by Premier for Hip/Knee in demonstration hospitals and subtracted the improvement rate for Hip/Knee found in the HQA data for non-demonstration hospitals. Our net estimate of annual improvement for Hip/Knee is 3.0 percent annual improvement.<sup>80</sup>

The proposal provides greater incentives for hospitals by lowering the quality threshold for an award to the 75<sup>th</sup> percentile, but it also reduces the incentive for the poorest hospitals to improve by eliminating the payment reduction for the poor performers. We assumed these two effects offset and the rate of improvement would be the same as the improvement observed under the demonstration.

We projected the quality score from 2010 to 2019 until the quality score is equal to 100 using the improvement rate for each clinical condition described in the methodology section. We projected savings as follows. We used savings, reported by Premier, associated with quality score thresholds for Heart Bypass Surgery and CAP.<sup>81</sup> We used the savings associated with quality improvement thresholds for Heart Bypass surgery to estimate savings for CABG, Heart

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<sup>78</sup> CMS linked receiving the full Medicare payment to participating in the program.

<sup>79</sup> Report found at: <http://www.premierinc.com/quality-safety/tools-services/p4p/hqi/hqid-measure-spec100106.pdf>

<sup>80</sup> Premier, "Centers for Medicare and Medicaid Services (CMS)/ Premier Hospital Quality Incentive Demonstration Project," April 2006. Hospital Quality Alliance (HQA) data found at: [http://www.cms.hhs.gov/HospitalQualityInits/25\\_HospitalCompare.asp#TopOfPage](http://www.cms.hhs.gov/HospitalQualityInits/25_HospitalCompare.asp#TopOfPage)

<sup>81</sup> "Performance Pays: Reliable Care Costs Less and Saves Lives," Press Conference Webcast, Orlando FL, June 2006.

Failure, and AMI. We estimated savings thresholds for Hip/Knee based on reductions in re-admission costs.<sup>82</sup>

We estimated the savings thresholds for CAP to be 9 percent as a hospital exceeds a score of 50 percent and 11 percent as a hospital exceeds a score of 75 percent. For Heart bypass surgery, we estimate an annual cost savings of 16 percent as a hospital exceeds a score of 50 percent and 14 percent as a hospital exceeds a score of 75 percent. We estimate savings of 4 percent at both the 50 percent and 75 percent thresholds. We indexed the hospital costs for each procedure to spending growth projections from CBO for inpatient services.<sup>83</sup>

We estimate savings to the Medicare program of \$31.6 billion over the 2010 through 2019 period for these five conditions (*Figure B-27*). In addition, we assume that the program would be extended to other conditions at the rate of 5 percent per year. This would increase 10-year savings for Medicare to \$40.9 billion.

As discussed above, the Obama P4P program would be required in the exchange as well as under Medicare and FEHBP. Also, because private plans often adopt payment and cost control methodologies developed in public plans, we assume that about 20 percent of private plans outside the exchange will adopt similar programs where they do not currently exist. We estimated savings for the exchange and private plans in proportion to the savings estimated for inpatient care under Medicare. This brings total 10-year savings for the Obama P4P program to \$48.7 billion (*Figure B-28*).

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<sup>82</sup> Estimates derived from Medicare 2003/2004 5 percent inpatient hospital files. Re-admission rate changes were assumed to be the same in 2005/2006.

<sup>83</sup> Growth rate taken from CBO 2007 Medicare Baseline.



**Figure B-27**  
**Projected Savings to Medicare from Implementing Pay-for-Performance for all Acute Care Hospitals**  
**for Five Clinical Areas**  
**(billions) <sup>a/</sup>**

Year	Projected Savings for Five Conditions						Savings from Expanding to Other Conditions	Total Medicare
	Acute Myocardial Infarction (AMI)	Coronary Artery Bypass Graft (CABG)	Heart Failure	Community Acquired Pneumonia (CAP);	Hip and knee Replacement	Total for Five Conditions		
2010	\$0.8	\$0.4	\$0.9	\$0.1	\$0.1	\$2.3	--	\$2.3
2011	\$0.8	\$0.5	\$1.0	\$0.1	\$0.1	\$2.5	\$0.1	\$2.6
2012	\$0.8	\$0.5	\$1.0	\$0.1	\$0.1	\$2.5	\$0.3	\$2.8
2013	\$0.9	\$0.5	\$1.1	\$0.1	\$0.1	\$2.7	\$0.4	\$3.1
2014	\$1.0	\$0.5	\$1.2	\$0.1	\$0.2	\$3.0	\$0.6	\$3.6
2015	\$1.0	\$0.6	\$1.3	\$0.1	\$0.2	\$3.2	\$0.9	\$4.1
2016	\$1.1	\$0.6	\$1.4	\$0.1	\$0.2	\$3.4	\$1.2	\$4.6
2017	\$1.2	\$0.7	\$1.5	\$0.1	\$0.2	\$3.7	\$1.5	\$5.2
2018	\$1.3	\$0.7	\$1.6	\$0.1	\$0.2	\$3.9	\$1.9	\$5.8
2019	\$1.4	\$0.8	\$1.7	\$0.2	\$0.3	\$4.4	\$2.4	\$6.8
2010-2014	\$4.3	\$2.4	\$5.2	\$0.5	\$0.6	\$13.0	\$1.4	\$14.4
2010-2019	\$10.3	\$5.8	\$12.7	\$1.1	\$1.7	\$31.6	\$9.3	\$40.9

a/ Baseline procedure costs estimated from 2005 MEDPAR file.  
Source: The Lewin Group estimates.

**Figure B-28**  
**Pay-For-Performance Program Savings under the Obama Plan: 2010 - 2019**  
**(billions)**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
Savings to Medicare											
Medicare	\$2.3	\$2.6	\$2.8	\$3.1	\$3.6	\$4.1	\$4.6	\$5.2	\$5.8	\$6.8	\$40.9
Savings to Privately Insured											
Non-Medicare in Exchange	\$0.1	\$0.5	\$0.6	\$0.6	\$0.7	\$0.8	\$0.9	\$1.0	\$1.2	\$1.4	\$7.8
Total Pay-For-Performance Savings											
Total Savings	\$2.4	\$3.1	\$3.4	\$3.7	\$4.3	\$4.9	\$5.5	\$6.2	\$7.0	\$8.2	\$48.7

Source: The Lewin Group estimates.







## Appendix C: Uniform Methodology and Data

We estimated the cost and coverage impacts of the health plans proposed by Senators McCain and Obama using The Lewin Group Health Benefits Simulation Model (HBSM). To facilitate comparison of these proposals, we adopted a standard set of data and assumptions that were applied uniformly across the two plans. While it is difficult to predict the precise impact of these proposals, the use of a standard methodology assures that comparisons of results across plans reflect differences in program design rather than mere inconsistencies in assumptions.

The HBSM is a micro-simulation model of the US health care system. Central to its design is a “base case” scenario depicting the distribution of health insurance coverage, as well as expenditures across a representative sample of households in the US under current policy for a base year. We assumed the base year to be 2010. The resulting database provides a detailed accounting of coverage and spending in the US health care system for consumers, employers, state and local governments, and the federal government.

We used the model to simulate the effect of the candidates’ plans on the number of people with health insurance from public and private sources. We estimated changes in health care costs for major payers for health services including households, employers, and governments. The impact of each proposal is determined by calculating the difference between coverage and health spending levels, under each proposal and coverage and spending levels under current law (i.e., our baseline simulation). Estimates of employer effects are provided by firm size, industry, earnings levels and current insuring status. Changes in consumer spending are provided by income, age, current insured status, and various demographic characteristics.

A full documentation of HBSM and the data used is available upon request.

### A. Population Data

Our baseline household data is based upon the Medical Expenditures Panel Survey (MEPS) data for 2002 through 2005, which are the most recent complete MEPS data now available. These data provide detailed information on health insurance coverage, health spending by type of service and source of payment, income and employment status and the demographic composition of the population. These data were adjusted to reflect more recent information on the distribution of the population by source of coverage, income, employment status and other socio-demographic characteristics provided in the Current Population Survey (CPS) for 2007.<sup>1</sup>

These data were then “aged” to be representative of the US population in 2006, which is the base year of the analysis. We used population growth projections from the Bureau of the Census and income growth assumptions consistent with those used by the Office of the Actuary of the Center for Medicare & Medicaid Services (CMS) in developing their health spending

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<sup>1</sup> Both the MEPS and the CPS data are corrected for under-reporting of Medicaid coverage, which is quite severe in the CPS. These databases provide comparable variable definitions that permit us to perform these necessary adjustments.

projections. We then adjusted the health spending data reported by households in the MEPS to replicate the distribution of total personal health expenditures by type of service and source of payment.

## B. Simulation of Medicaid Eligibility and Enrollment

The Obama plan includes an expansion in eligibility for the Medicaid and SCHIP programs. We simulated this using the CPS data for 2007. We used these data to identify people eligible for these programs under current law using the actual income eligibility levels used in each state under current law by class of eligibility (e.g., children, parents and childless adults). We then used the model to identify the number of people who would be eligible for coverage under the Obama plan including parents and non-custodial adults living below 150 percent of the FPL.

The impact of these expansions will vary across states, due to the wide variation in income eligibility levels under the current Medicaid program. Although eligibility levels vary considerably across states, children are usually covered up to 200 percent of the FPL. Parents are eligible if their income is below levels averaging about 50 percent of the FPL. Noncustodial, nondisabled adults generally are not eligible at any income level, except in about 6 states that have been granted waivers to cover this population.

Once we identified the newly eligible population, we estimated the number of people who would enroll using multivariate analyses of historical enrollment levels under the existing program. These analyses show how enrollment varies with age, income, eligibility group and whether they have access to employer-sponsored insurance (ESI). The model also shows how enrollment levels are affected when participants are required to pay a premium, as is done in some states for people at the higher end of the eligibility scale.

Our program cost estimates were estimated using the health spending data in HBSM for those who are simulated to become covered under the expansion. For newly insured people, we assumed that their utilization of health services would increase to the levels reported by insured people with similar age, gender, income, and health status characteristics.

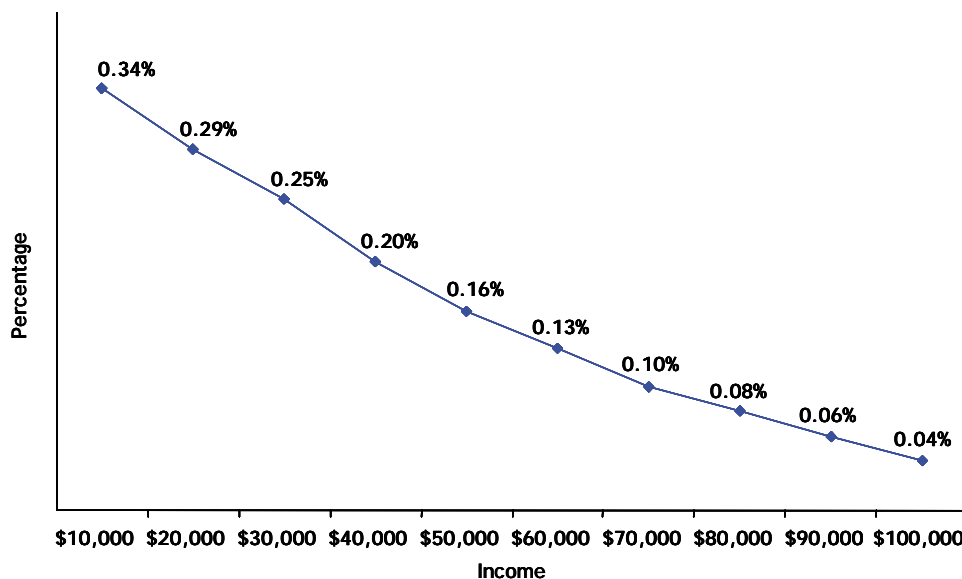
## C. Premium Subsidies

Both proposals include features that would provide subsidies to assist people in purchasing private insurance coverage. The McCain plan provides tax credits for private health insurance including both those with employer coverage and those with non-group health insurance. The Obama plan also provides subsidies for the purchase of health insurance for people who have too much income to qualify for Medicaid but not enough income to be able to afford health insurance.

In our analysis, we assume that people treat these subsidies as a reduction in their cost of health insurance. We assume that these subsidies induce some of the uninsured to choose to purchase non-group coverage. We estimate the number of people who obtain insurance, based upon a multivariate analysis of how the likelihood of purchasing coverage increases as the cost of insurance, is reduced. These data show that, on average, each 1 percent reduction in the price

of insurance is associated with a 0.34 percent increase in the percentage of people purchasing coverage.<sup>2</sup> However, as shown in *Figures C-1* and *C-2*, these data indicate that the magnitude of the price response tends to decline at higher income and age levels. These price response factors are used as probabilities to select eligible people in the model to take coverage in response to the subsidies.

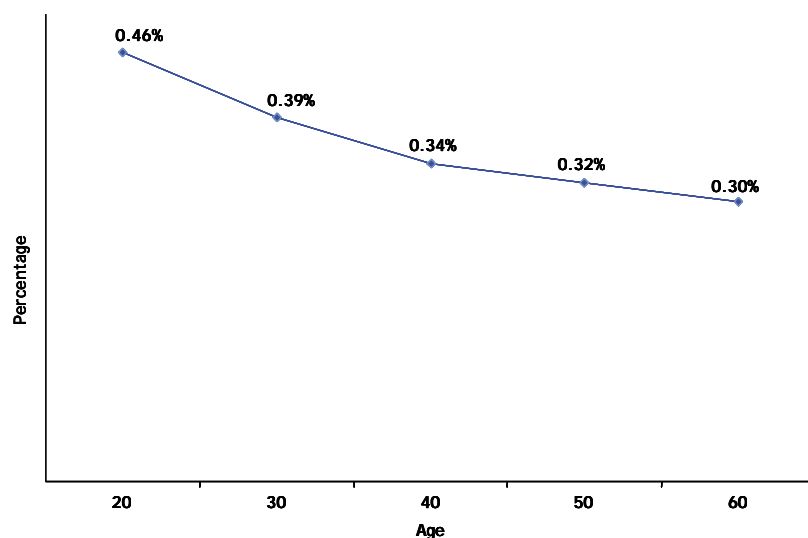
**Figure C-1**  
Percentage Increase in Coverage Resulting from a One Percent Reduction  
in Premiums by Income Level<sup>a/</sup>



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

<sup>2</sup> Students of economics will recognize this as a price “elasticity.”

Figure C-2  
Increase in Coverage Resulting from a One Percent Reduction in Premiums by Age<sup>a/</sup>



a/

Indicates a price elasticity ranging between -0.46 and -0.30 by age.

Source: The Lewin Group estimates.

Once changes in sources of coverage are modeled, HBSM simulates the amount of covered health spending for each affected individual based upon the health utilization and spending data reported for each individual selected to become covered. This includes simulating the increase in utilization among newly insured people. In general, we assume that utilization among newly insured people will increase to the level reported by insured people with similar characteristics. The benefit costs are estimated from these spending data based upon the covered services and cost-sharing provisions of a typical health plan, or the minimum benefits package that is specified under the Obama plan.<sup>3</sup>

#### D. Employer Impacts

Both candidates' plans would affect the employer's decision to provide insurance. For example, the McCain plan lowers the cost of insurance for small employers by permitting cross-state sale of insurance to circumvent the state mandated benefits and rating requirements. The Obama plan provides a tax credit to small employers for up to half of premium contributions and establishes a governmental reinsurance program that reduces the cost of employer health insurance. Both plans also include provisions designed to reduce health care costs (e.g., malpractice reforms, etc.) that would influence employers' decisions about offering coverage.

Modeling these effects requires a representative sample of employers with detailed information on the characteristics of each employer, together with information on the characteristics of each worker and dependent in the firm, including health spending information. Because no one database provides this combination of employer and employee data, we developed "synthetic

<sup>3</sup> For illustrative purposes we use the Blue Cross Blue Shield "Basic" plan provided under the Federal Employees Health Benefits Program (FEHBP) to estimate benefit costs.

firms” from the available data. We also developed a model of insurance markets that simulates the process of rating health plans, based upon the insurance market rating laws in the 50 states and the District of Columbia.

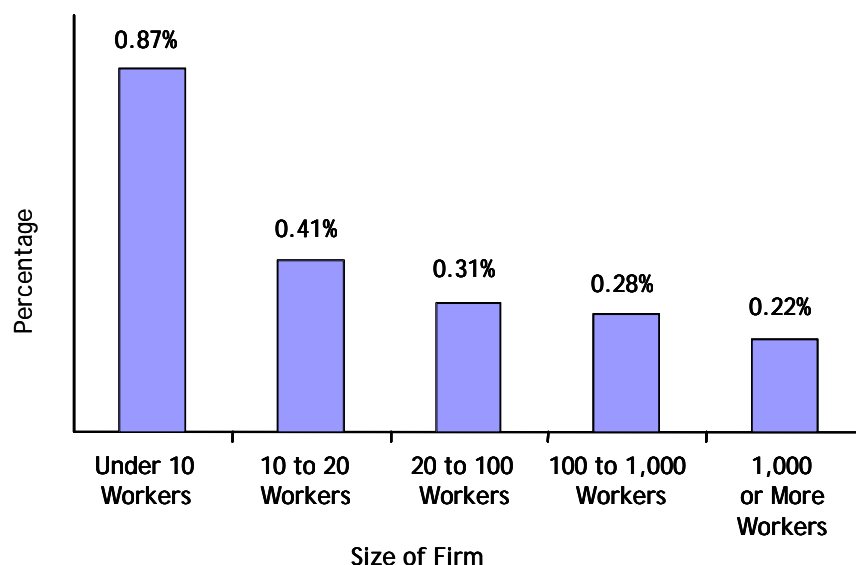
Our approach was to match each working individual in MEPS to one of the firms in the 2006 Kaiser Family Foundation and the Health Research and Educational Trust (HRET) survey of 2,000 employers, including insuring and non-insuring firms. We statistically matched these plans with a sample of employers in the 1997 Robert Wood Johnson Foundation (RWJF) to provide data on workers’ characteristics. Workers were assigned to firms that are consistent with the demographic and income characteristics of the employer’s workforce.<sup>4</sup> We then “populated” each firm that an individual is matched to by randomly assigning additional MEPS workers to the firm who match the firm’s workforce characteristics. This provided complete employer units with all of the information required to simulate employer decisions.

The employer tax credit in the candidates’ plans was modeled assuming that it will be treated by employers as a reduction in the price of insurance. We estimated the number of non-insuring firms that respond by offering coverage based upon a Lewin multivariate analysis of how the percentage of employers offering coverage changes as the price of insurance changes. As shown in *Figure C-3*, for firms with 10 or fewer workers, a 1 percent reduction in premiums is associated with a 0.87 percent increase in the number of employers offering coverage. It also shows that the price response for employers declines rapidly as firm size increases, and that there is very little price response in the largest firm size groups.

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<sup>4</sup> The Kaiser/HRET data provide information on the distribution of workers by wage level only. We statistically matched the Kaiser/HRET data with employers surveyed in the 1991 Health Insurance Association of America (HIAA) employer survey data, which provides detailed information on the characteristics of each employer’s workforce including number of workers by part-time/full-time status, age, gender, medical policy type, and the coverage/eligibility status of employees.

Figure C-3  
Percent Increase in Firms Offering Coverage With a One Percent Reduction in Premiums



Source: The Lewin Group estimates.

We also used these data to estimate the impact of the various elements of the candidates' plans that would reduce employer health insurance premiums. For example, the McCain plan enables firms to bypass state mandated benefits and premium rating regulations and emphasizes coordinated chronic care under government programs. In addition, the Obama plan includes provisions to fund the adoption of health information technology, establishes an institute for clinical effectiveness and establishes diseases management and care coordination initiatives. All of these provision's would reduce the cost of employer insurance. We simulated the impact of these changes in premiums on the number of employers offering insurance based upon the price response assumptions shown in *Figure C-3*.

The model reflects variations in firm price elasticity depending upon the characteristics of the firm. For example, the model shows that the firm price elasticity tends to decline as age and income rise, as shown in *Figures C-4* and *C-5*. This results in a lower estimated price elasticity among currently insuring firms -- averaging about -0.56 for firms with 10 or fewer workers -- because the employers that offer coverage tend to have older and more highly compensated workers.

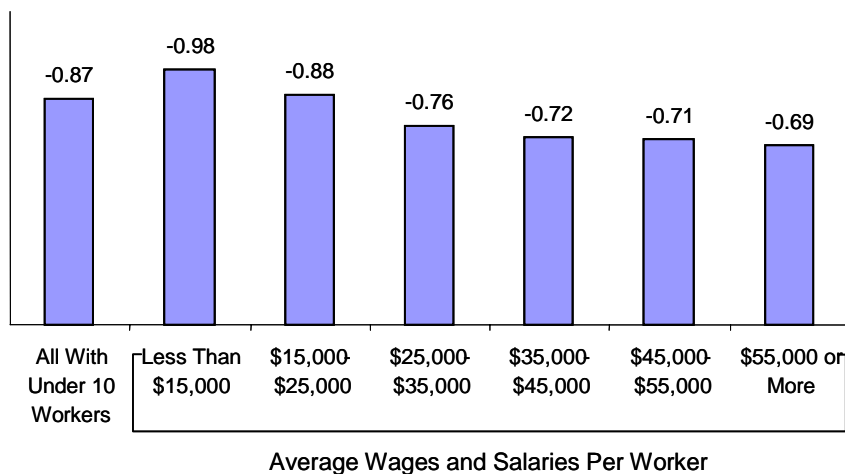
In addition, we estimated multivariate models predicting the percentage of the premium paid by the worker using the RWJF employer data. These equations measure how premium shares vary with the characteristics of the firm, their workforce and the amount of the total premium. These amounts are used to estimate the cost of insurance for workers in each firm selected to offer coverage in response to the program.

Once firms are selected to offer coverage, we simulate enrollment among workers assigned to these plans. The enrollment decision is simulated with a multivariate model of the likelihood that eligible workers will take the coverage offered to them based upon data reported in the 1996 MEPS data for people offered coverage through an employer. The model measures how



take-up varies with the characteristics of the individual as well as the employee premium contribution required by the employer.

**Figure C-4**  
Employer Health Insurance Price Elasticity Estimates for Firms with Under 10 Workers by Average Wages and Salaries per Worker <sup>a/</sup>



a/ Based upon multivariate analysis of the 1997 Robert Wood Johnson Foundation (RWJF) Survey of Employer Characteristics. "Health Benefits Simulation Model (HBSM)," The Lewin Group, August 2003. Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

**Figure C-5**  
Employer Health Insurance Price Elasticity Estimates for Firms with Under 10 Workers by Age of Workers <sup>a/</sup>



a/ Based upon multivariate analysis of the 1997 Robert Wood Johnson Foundation (RWJF) Survey of Employer Characteristics. "Health Benefits Simulation Model (HBSM)," The Lewin Group, August 2003. Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Finally, based upon a review of the economic literature, we assume that changes in employer costs resulting from these proposals would be passed on to workers in the form of changes in wage growth over time. For example, policies that reduce employer costs would result in a corresponding increase in wages for affected workers. Similarly, increases in employer health benefits costs are assumed to be passed on to workers as wage increases.<sup>5</sup> HBSM also simulates the impact of these changes in wages upon federal and state tax revenues.

## E. Economic Assumptions

In this analysis, we projected the impact of each health reform proposal on health spending and the federal budget for the 2010 through 2019 period. In developing these projections, we used assumptions developed by the Office of the Actuary of CMS on the growth in Gross Domestic Product (GDP), population growth, and the growth in health spending by type of service and source of payment.

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<sup>5</sup> Marginal tax rates are imputed to the MEPS household data based upon the tax rate data collected in the CPS data.