

Technical Assessment of Health Care Reform Proposals

Proof Report

Prepared for:

**The Colorado Blue Ribbon Commission for Health Care
Reform**

Date: August 20, 2007

Figure 58
Transitions in Coverage under CHS Single Payer in 2007/2008 (thousands)

Base Case Coverage	Total	Single Payer Program	Private Coverage					Uninsured
			Employer	Non-Group	CHAMPUS	Medicare (incl. dual eligibles)	Medicaid / CHP+	
Employer	2,691.7	2,691.7	0.0	0.0	0.0	0.0	0.0	0.0
Non-Group	158.9	158.9	0.0	0.0	0.0	0.0	0.0	0.0
CHAMPUS	112.4	112.4	0.0	0.0	0.0	0.0	0.0	0.0
Medicare (incl. dual eligibles)	413.0	413.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicaid / CHP+	452.1	452.1	0.0	0.0	0.0	0.0	0.0	0.0
Uninsured	791.8	791.8	0.0	0.0	0.0	0.0	0.0	0.0
Total	4,619.9	4,619.9	0.0	0.0	0.0	0.0	0.0	0.0

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

2. Impact on Statewide Health Spending

As discussed above, we estimate that health spending for Colorado residents will be about \$30.1 billion in 2007/2008. This includes spending for all health services by all payers including Medicare Medicaid, ESI, non-group insurance, workers compensation and various safety-net programs. Spending includes both payments for services and insurance, and program administration.

The single payer model would have several impacts on statewide health spending. There would be an increase in health services utilization as persons who are uninsured or underinsured under the current system become covered. Utilization will also increase slightly for those individuals previously covered in a less generous plan. However, these increases in costs would be largely offset by reductions in administrative costs for insurers and providers. There also would be savings due to bulk purchasing of prescription drugs and durable medical equipment.

Statewide health spending under the CHS Single Payer in Colorado in 2007/2008 would decrease by \$1.4 billion from \$30.1 billion under the current system to \$28.7 billion (*Figure 59*). This includes benefits (including administration) of \$26.58 billion, household out-of-pocket payments of \$1.33 billion and supplemental insurance of \$795 million. Most of the decrease in overall health spending from all payers under the CHS single payer system results from reduced administrative costs of about \$1.86 billion.

Figure 59
Distribution of Statewide Health Spending under CHS Single Payer in 2007/2008
(millions)

	Benefits Payments	Administrative Costs	Total Spending
Change in State-wide Health Spending under CHSP			
Current State-wide Health Spending for All Payers	\$27,838	\$2,262	\$30,100
Change in State-wide Health Spending under CHSP	\$461	(\$1,856)	(\$1,395)
State-wide Health Spending under CHSP program	\$28,299	\$406	\$28,705
Distribution of Spending Under CHSP Program			
Benefits Covered under CHSP	\$26,237	\$341	\$26,578
Household out-of-Pocket Payments ^{a/}	\$1,332	--	\$1,332
Supplemental Insurance	\$730	\$65	\$795
Total	\$28,299	\$406	\$28,705

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

Overall health spending would decline by \$1.4 billion (*Figure 60*). As more people seek health care and providers are paid on a composite of all payer rates, spending would increase by \$1.78 billion. In addition, the CHS single payer provides for increased utilization in home and community based services. Because there would be a single source payer, there would be no cost shifting under the CHS program. Increased spending would be partially offset by the \$2.85 billion in savings from administration and another \$322 million from the bulk purchasing of drugs.

Figure 60
Changes in Statewide Health Spending under CHS Single Payer in 2007/2008 (millions)

Current State-wide Health Spending for All Payers	\$30,100
Change in Health Services Expenditures	\$1,774
Change in acute care utilization for newly insured	\$939
Change in acute care utilization for currently insured	\$70
Change in long term care utilization	\$765
Reimbursement Effects	\$0
Payments for previously uncompensated care	\$682
Reduced Cost Shifting ^{a/}	(\$682)
Bulk Purchasing Discounts	(\$322)
Bulk Purchasing of Prescription Drugs and Durable Medical Equipment ^{b/}	(\$322)
Change in Administrative Cost of Programs and Insurance	(\$2,847)
Insurer Administration	(\$1,856)
Hospital Administration	(\$322)
Physician Administration	(\$669)
Total Change in State Health Spending	(\$1,395)

a/ Assumes change in provider payment resulting from previously uncompensated care are passed on to CHSP in the form of lower payment rates.

b/ Assumes 13 percent additional discount on drugs and medical equipment.

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

a. Impact on Utilization of Health Services

The expansions in coverage and benefits under a single payer plan would result in increased utilization of health services. Utilization of services for uninsured and underinsured people would generally increase due to expanded access to services under the program. The elimination or reductions in patient cost-sharing would also increase utilization for those who now face substantial co-payments and deductibles. In addition, under mandated benefits, utilization for certain services would increase due to the expansion in coverage for those services.

However, these increases in utilization would be partly offset by reduced spending for avoidable complications in health conditions and reduced spending in avoidable health conditions resulting from increased primary care utilization. Below we discuss the utilization impacts of implementing a single payer plan.

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

Using this methodology, we estimate that health spending among the currently uninsured population would increase. That is, savings from improved primary care would be more than offset by increased use of non-emergency care. We estimate an increase in spending due to utilization will increase to a total of \$939 million in 2007/2008.

Some insured have a benefit package that does not cover certain services including prescription drugs, dental care, orthodontia and medical equipment. Often times, these individuals access such services through government-funded clinics and health centers or forego services. In addition, a smaller underinsured population is covered through government programs that only offer a limited benefit package. Under a single payer plan, these individuals will have access to a full range of comprehensive health care services which would increase utilization and costs.

In this analysis, we assume that utilization of these services by people who are not currently covered for these services would increase to the levels observed among those with similar demographic and health status characteristics who do have coverage for these services. Spending under the single payer will increase by about \$70 million for under-insured people.

The proposal makes long term care services available to all individuals. Room and board and medical expenses would continue to be covered for the Medicaid/CHP+ eligible population in the Single Payer. However, for those who are not eligible, only the medical component would be covered. The individual would be responsible for room and board. The proposal also requires a 25 percent increase in utilization for home and community-based long term care services. We estimated that the change in health spending for utilization of long term care services would be \$765 million in 2007/2008.

1. Change in Government Health Spending

The program would have significant implications for both the state and federal governments. We present estimates of program operation costs and revenues for both the state and federal governments.

a. Sources and Uses of Funds

Figure 61 presents our estimates of sources and uses of funds under the single payer programs. Overall state spending for these programs would be about \$26.58 billion. This would be funded in-part with \$3.07 billion in state spending and \$8.43 billion federal spending transfer that would have occurred under current law. It is supplemented with about \$8.18 billion in individual income tax payments, about \$6.51 billion in employer payroll tax revenues, and \$336 million in alcohol and tobacco taxes.

Under the single payer program, total benefit payments to providers will be about \$25.25 billion in 2007/2008. We estimate that \$322 million will be saved in 2006 from bulk purchasing discounts on prescription drugs and durable medical equipment. We also estimate a savings of \$682 million in provider payment adjustments. This includes physician and hospital administrative savings as well as an allowance for reduced cost shifting. Under the current system, uncompensated care from services to the uninsured and under-insured is shifted to other payer sources (primarily private payers). A single payer plan will cover almost all residents, thereby reducing cost shifting which we estimate to be \$682 million. This savings is included in our estimate of adjustments to provider payments. Administrative savings for hospitals would total \$322 million and \$669 million for physicians.

We assume that federal funding would continue for Medicaid (including long-term care and funding for the Medicare/Medicaid duals), and SCHIP and would be transferred to the state to help fund the CHS Single Payer, totaling \$1.55 billion. We also assume that funding for the Medicare eligible population would also be transferred to the state, totaling \$5.81 billion. In addition funding for military personnel under CHAMPUS, Indian Health Services and federal employees benefits, including retirees totaling \$1.07 billion, would be transferred to the state to help fund the Single Payer. The estimated total revenue from federal government transfers is \$8.43 billion in 2007/2008.

New revenues include increasing the income tax by 8.1 percent, bringing the income tax rate to 12.4 percent compared to 4.3 percent currently, which would raise \$8.18 billion in 2007/2008. An employer payroll tax of 6 percent would raise \$6.5 billion in 2007/2008. Alcohol and tobacco taxes increase would raise \$336 to fund the program. Additionally, savings from employers that result in increased wages would result in additional tax revenues of \$56 million. Total new revenue to fully fund the program would be about \$26.58 billion in 2007/2008.

Figure 61
CHS Single Payer Costs and Revenues in 2007/2008 (millions)

Uses of Funds		Sources of Funds	
CHSP Acute Care Benefits Costs	\$23,255	State & Local Government Program Savings	\$3,072
Benefits costs at current payment rates	\$25,250	Medicaid / CHP+	\$1,427
Bulk Purchasing Savings	(\$322)	Employee and Retiree Benefits ^{/a}	\$378
Reduced Cost Shifting	(\$682)	Workers Compensation	\$702
Hospital Admin. Savings	(\$322)	Other Safety Net Programs ^{/b}	\$565
Physician Admin. Savings	(\$669)	Federal Government Transfers	\$8,425
CHSP Long Term Care Benefits Costs	\$2,982	Medicaid / CHP+	\$1,545
Nursing Home	955	Medicare	\$5,810
Home & Community Based Services	\$1,276	CHAMPUS / VA	\$752
Home Health	\$751	Indian Health Service	\$40
		FEHBP (employees & retirees) ^{/a}	\$278
CHSP Program Administration	\$341	Taxes to Fund Program	\$15,025
		Employers (6% payroll tax)	\$6,513
		Increase personal income tax rate by 8.1%	\$8,176
		Tobacco Tax Increase ^{/c}	\$210
		Alcohol Tax Increase ^{/c}	\$126
		State Income Tax Gain/(Loss) from Wage Effects	\$56
Total Costs	\$26,578	Total Revenues	\$26,578

a/ Includes net savings after additional benefits for employees and retirees and payroll taxes.

b/ Includes care currently paid for by other safety net programs. Assumes waiver is approved to allow state to continue to receive Federal DSH funding to be used for the program. Source: The Lewin Group estimates using the Health Benefits Simulation Model.

2. Impact on State and Local Budgets

Under the CHS Single Payer, all state and local funding for programs now serving people shifted to the single payer plan would be transferred to the single payer program. State spending for Medicaid and CHP+ (i.e., state share), as well as state and local government spending for safety-net programs, and worker's compensation totaling about \$3.07 billion under current law would be transferred to the Single Payer (*Figure 61*).

While there would be no net change in spending for public health benefits programs, there would be substantial savings for state and local worker coverage for employees and retirees. This results mostly from the fact that early retirees (i.e., pre Medicare) would largely become covered under the single payer program. Because employers are not required to pay a payroll tax for the early retirees that they cover, the state, as an employer, saves the full cost of covering this population. Additional savings would come from safety net programs and worker's compensation.