

## Responses to Commissioner Questions from the Conference Call July 7, 2007

### General Questions

**Question:**

***The slides titled “Changes in State Health Spending (fill in the blank)” The question I have is from “where” is this spending currently to “who.”***

Answer:

These “changes in state health spending” slides compare current state spending in 2007/2008 (“baseline spending”) to spending as if the health reform proposal were fully implemented in 2007/2008. For your reference, Lewin’s has published a separate report detailing the 30.4 billion in current (2007/2008) state spending (baseline), entitled “Health Spending in Colorado”.

**Question:**

***What are “wage effects”? What is the significance of the “before” and “after” designation.***

Answer:

The Lewin Group’s Health Benefits Simulation Model (HBSM) assumes that changes in employer costs for health benefits are passed-on to workers in the form of changes in wages. Thus, increases in employer costs are assumed to be passed-on to workers in the form of reduced wages while, decreases in health benefits expenses are passed-back to employees in the form of increased wages. We assume that this wage adjustment would occur among government employers as well, assuming that government compensation packages will be adjusted to remain competitive in the labor markets. We assume that this pass-through occurs among both insuring and non-insuring firms whose labor costs are affected by the proposal due to changes in health benefits or payroll taxes imposed as part of the program. We also assume these wage changes would occur in response to both mandates affecting employers and voluntary changes in employer coverage induced by health reform.

Our pass-through assumption is based upon the economic principle that the total value of employee compensation, which includes wages, employer payroll taxes health benefits and other benefits, is determined in the labor markets. Thus, for example, a reduction in the cost of one form of compensation would cause wages and other compensation to be bid up in the labor markets resulting in an eventual pass-through of these savings to the worker. Similarly, increases in compensation costs would lead to reductions in wages or other benefits to reflect the change in costs.

There is considerable agreement among economists that these pass-throughs would occur in response to changes in employer benefits costs.<sup>1</sup> However, there is disagreement over the period of time over-which these adjustments would occur. It is likely that these adjustments would often take the form of reduced wage growth over-time. However, the full amount of the pass-through could take several years to materialize. For illustrative purposes, we generally present our estimates with and without wage effects.<sup>2</sup> In the July 7<sup>th</sup> presentation, the slides designate these two estimates as “before wage effects” and “after wage effects”.

Additional detail on wage effects is found in the HBSM documentation, including modeling the impact of wage effects on state and federal tax revenues.

**Question:**

***What are “reimbursement effects?”***

Answer:

Reimbursement effects are changes in provider reimbursement (payments to providers) due to the reform proposal, as compared to current provider spending. Currently, Lewin estimates that providers provide \$777 million of “uncompensated care” which we define as free care provided to uninsured individuals. (Uncompensated care does not include bad debt from individuals who are insured.) Hospitals are the largest providers of uncompensated care.

Because all four reform proposals reduce the number of uninsured by providing them with insurance, hospitals and other providers now receive payment for care to these newly insured individuals that would have been uncompensated under the current system. The effect is a windfall to providers, especially those that provide a substantial amount of uncompensated care in the current system.

The other component of provider reimbursement effects is cost-shifting. A long standing issue in health reform is the potential for cost shifting as people are moved to programs with differing provider payment levels. For example, payment rates for Medicaid, and to a lesser extent, Medicare are typically below the average cost of providing those services.

Research shows that providers pass-on a substantial portion of these shortfalls in reimbursement to private-payers in the form of higher charges, which is known as the “cost-shift.” Research also shows that private-payer payments increase

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<sup>1</sup> See, for example, James Heckman, "What Has Been Learned About Labor Supply in the Past Twenty years?" American Economic Review, (May 1993).

<sup>2</sup> See, for example, Jonathan Gruber and Alan B. Kreuger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers Compensation Insurance," in Tax Policy and the Economy (1991); Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," American Economic Review, (forthcoming); and Lawrence H. Summers, "Some Simple Economics of Mandated Benefits," American Economic Review (May 1989).

as payment shortfalls under public programs rise and decline as payment shortfalls under public programs decrease. Thus, private payer payments not only increase as public payer rates decline, they decline as public payer rates increase. This symmetrical relationship between public and private payment rates for hospitals suggests that a portion of the change in reimbursement in these reform proposals will be passed on to private payers, whether it is a net increase or a net decrease in payment rates. In the Colorado analysis, we assumed that 40 percent of all changes in provider reimbursement are passed on to private payers as a change in prices (e.g., lower negotiated rates).

Additional detail on provider reimbursement effects is found in the HBSM documentation.

**Question**

*The slide titled “Transitions in Coverage.....” It is not clear to me where the current data is versus predicted data due to the change.*

Answer:

The first column of data (column two) contains the current coverage status for the 4.6 million people in Colorado in 2007/2008. The remaining columns illustrate how the coverage status for these individuals changes under the proposed health reform. For example, (row three, column two) tabulates those with employer coverage currently. The remainder of row three demonstrates whether and to what extent those with current employer coverage would “transition” into the same or different types of coverage under the reform. For example, row three, column eight counts those with current employer coverage that transition into Medicaid/CHP+ coverage under the reform proposal. This phenomenon is known as “crowd-out” and is often of policy interest.

**Question:**

***Is there nothing in any of these evaluations that examine the opportunities translated into dollars for lowering or stabilizing health care costs (not insurance rates)?***

Our analysis presents estimates of the effect of the four proposals on health spending, including changes in administrative costs and provider reimbursement levels. Beyond these effects, there is nothing inherent in the policies modeled that we can show would reduce or stabilize spending.

The single-payer proposal could result in substantial savings by adjusting provider payments each year so that health spending grows at a slower rate than is now projected. However, since no such policy was specified, we assume that costs would grow at the same rate as under current law.

**Question:**

***How are we addressing our legislative charge to study underinsurance? Both the SEIU and the CASHU proposals contemplate pretty basic benefits packages. If you look at the Lewin numbers for example comparing SEIU's and the No Larimer County folks proposals you see some but not a significant difference in cost shifting numbers. I would expect perhaps a larger difference there if they were accounting for the difference in benefits package. There is also a pretty significant difference between SEIU's cost shifting numbers and CASHU's but I assume that may relate to the significant difference in the number of uninsured covered by each proposal. I want to know, at the end of the day, whether or not we can see what the difference in benefits packages does to the numbers re: cost shifting. For example, does a \$35,000 benefits limit or lower outpatient hospitalization limit impact cost shift or not, and if so, by how much? I think it is difficult to fully evaluate the two low benefit package proposals without that information.***

Answer:

Out-of-pocket payments made by families include expenditures on any required cost-sharing provisions of the benefit package as well as expenditures on care that was obtained but was not a covered benefit. Although there is no agreed upon definition for underinsurance, we can show how spending is affected under these policy options for those with high out-of-pocket costs under current law (e.g., 10 percent of income, or \$10,000 or more in out-of-pocket spending under current law etc.). We can include such results in our final report.

**Question:**

***Will the final report explain how Lewin is modeling employer participation (assumptions, etc)?***

Answer:

The RFP requires Lewin to provide a detailed list of assumptions and considerations for each model in the preliminary and final reports, in plain English, along with a discussion of the results of any sensitivity analyses. In addition, the final report will include an executive summary of approximately 20 pages that is understandable to the layperson. A detailed technical report will follow the executive summary and it will include detailed documentation of all modeling methodologies employed, assumptions, findings, and the results of sensitivity analysis. The Commission also may wish to include the full HBSM documentation in an appendix.

**Question:**

***Could we please make it crystal clear what provider rates Lewin is using in the public documents, including PowerPoint presentations as well as the preliminary and final reports?***

Answer: Yes.

**Question:**

***How do you approach pricing out the benefit package? Does your actuary use any data other than the “commercial population.” What makes you think that the uninsured are represented by a “commercial population?”***

Answer:

For Medicaid/SCHIP expansions, we use Medicaid/SCHIP per-enrollee spending for children and parents under the existing program as a basis for estimating costs for newly enrolled people.

For programs that expand private insurance, we estimate costs based upon experience for commercial populations. Our approach is to assume that utilization of health services for uninsured people would adjust to the levels reported by insured people with similar characteristics including: age, gender, pregnancy status and health status. Thus, our estimates reflect differences in the demographic composition of the newly insured population. The increase in spending tends to be small because the uninsured tend to be younger than the commercial population.

**Question:**

***Where are the illegals in this—they can’t be put on Medicaid and I don’t see them being broken out. Consider the CO pop of 4.5 million and Urban Institute estimate of 175,000 to 200,000 illegals in Colorado in 2000. If you drive uninsured to 2 percent as one proposer said modeling did, you have 90,000 people uninsured. Even if ½ of illegals are insured, this means that by back of envelope, all of the uninsured are illegals. Everyone else is insured.***

Answer: ?

We estimate that there are about 200,000 non-citizens in Colorado who would not meet the residency requirements to qualify for Medicaid. This includes the undocumented and no-citizens who have been in the US for less than 5 years.

Data on the number non-citizens by years in the country is taken from the Current Population Survey data. Census believes that undocumented residents are included in their population estimates (which is a survey of residents regardless of citizen and immigrant status), although it does not separate the non-citizen population into the documented and undocumented groups.

# Proposal-Specific Questions

## Health Care for All Colorado Proposal Questions

### Question:

*In the single payer proposal, Lewin assumes an additional 13% discount for bulk purchasing of medical equipment. Other discounts assumed for Rx. Where do these assumptions derive from? The stated assumption (slide 5) that Medicaid is negotiating discounts 3X greater than are private insurers is not supported by other reliable data I've seen — what is this statement based on?*

Answer:

We assume that the program would be able to purchase drugs at the same prices now charged under Medicaid. CMS estimates that Medicaid discounts/rebates are about 21 percent. This compares with an average discount/rebate of 8 percent for private insurers, which we base on interviews with industry experts.

### Question:

*Also in the CHSP proposal Lewin makes assumptions about the reduction of admin expenses but I do not see the basis for these assumptions — the costs to build a bureaucracy to administer the program, or to contract out for administration?*

Answer:

A single-payer system replaces the current system of multiple public and private insurers with a single source of payment for the full amount of covered services. This eliminates both the complexity of diverse insurer rules and patient billing for un-reimbursed amounts. The single-payer system also replaces hospital billing for individual patients with annual operating budget, which effectively eliminates claims filing functions for hospitals (Claims filing would continue for foreign patients). Administrative savings would be realized at both the insurer and the provider level as follows.<sup>3</sup>

- **Insurer Administration:** The single-payer program would extend large-group economies of scale throughout the health care system by covering all individuals under a single insurance mechanism. This would eliminate the costs associated with underwriting, transition in coverage, and maintaining the administratively cumbersome linkage between employers and insurers.
- **Physicians Administration:** The single-payer approach would substantially reduce claims-filing costs for physicians by standardizing the means of

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<sup>3</sup> Sheils, J., et al., "National Health Spending Under a Single-Payer System: The Canadian Approach," Staff Working Paper, The Lewin Group, January 8, 1992.

reimbursement through a single-payer and by providing full reimbursement through a single source using a standardized electronic claims-filing process. Standardization of coverage would also reduce physician costs related to adjudication of claims and negotiation of selective-contracting arrangements.

- **Hospital Administration:** The single-payer proposal standardizes payment levels and rules for reimbursement. It also eliminates the need for negotiating discounts with payers.

We estimate these savings based upon a prior Lewin Group study of the impact of a single-payer model on administrative costs.<sup>4</sup> We assume that the cost of administration is similar to administrative costs under the Medicare program, which can be thought of as a single-payer program for the elderly. We adjusted these costs to reflect the unique characteristics of CHSP proposal.

Additional detail on calculating administrative costs is found in the HBSM documentation. Implementation costs are not included in any of the proposals cost estimates. They are modeled as if fully implemented in 2007/2008.

**Question:**

***In all of these evaluations, I don't see the calculation for changes in premium tax revenue (the most obvious being the CHSP proposal). Are those present in these proposals?***

Answer:

We have not yet modeled premium tax effects under the proposals.

**Question:**

***Why are the single payers not covering adult dental and how much would that add to the cost?***

Answer:

The CHSP proposal expressed interest in providing rich, comprehensive benefits including long term care. Therefore, it was initially modeled using a Medicaid benefits package. Medicaid provides only limited dental benefits to adults. Adding dental benefits would be a refinement to the proposal. If the proposer chose to modify the benefit package to include adult dental benefits, we could price out the cost of this addition.

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<sup>4</sup> Sheils, J., et al., "O Canada: Do We Expect Too Much From Its Health System", *Health Affairs*, Spring 1992.

**Question:**

***How are ERISA issues handled under this proposal? Do you assume an ERISA waiver?***

Answer:

We assume that a single payer system does not conflict with ERISA and therefore does not need a federal waiver. This is what most experts seem to think, but we can not know for sure until it is tested in court.

We do assume that the federal government agrees to block grant Medicaid and Medicare funds for Colorado residents. Failure to get a waiver to block grant Medicare (which is the likely outcome) does not substantially alter our estimates because it is relatively simple to coordinate reimbursement with the single-payer providing wrap-around coverage for Medicare co-pays and uncovered services.

Failure to get a waiver to block grant Medicaid would be a much more serious problem, because the state is required to establish income eligibility for people to qualify for Medicaid. Most people would no longer come in to apply for Medicaid since the alternative is that they would be covered under the single-payer anyway. Processing income eligibility for every person in the state would be prohibitively expensive, so it is unclear how the state would continue to qualify for Medicaid funds.

**Colorado Association of Health Underwriters Proposal Questions**

**Question:**

Regarding using CICIP funds for financing the CASHU proposal.... Since about 75% of CICIP funds are federal, how are assumptions made to altering the payout to providers versus the practicality of where the funds come from (the federal government)?

Answer:

This proposal increases state expenditures for the newly covered populations. This additional spending can be used as a match for federal DSH payments, although a waiver may be required. CMS has always been eager to let states use their DSH dollars to cover new populations.

**Question:**

***I would like to know how Lewin came up with the PMPM cost of \$178 for the core benefit plan — what is the basis for that cost estimate? I believe this to be a significant percentage above actual cost for this type of plan, based on my experience in the market with these sorts of plans.***

Answer:

Our actuary provided estimates of premiums by age and family status. We then calculated actual program cost by weighting by premium to reflect the age of the newly enrolled population. Newly covered people tend to be younger than average. These premium estimates will be included in the report.

**Question:**

***Does the CASHU proposal provide a guaranteed issue core benefit package that is available to all or just to those being provided subsidies?***

Answer:

All Coloradans residents, except those covered under Medicare, Tricare/CHAMPUS and Federal Employee Health Benefits, would be required to obtain coverage at least as comprehensive as the guaranteed issue Core Limited Benefit Plan. Self-employed individuals would also be required to have coverage. The guaranteed issue Core Limited Benefit Plan is available even to those that are not eligible for subsidies.

## SEIU/CAPE Proposal

### Question:

***Are current Medicaid/CHP+ eligibles and enrolled still getting the same benefit plan under this proposal or is their current coverage replaced by the skinny package that the expansion population gets?***

Answer:

Individuals who are currently eligible for Medicaid and CHP+ would receive the current benefits under those programs, including pharmacy benefits and long term care. Applicable cost-sharing requirements under the Medicaid program would still apply. Parents and childless adults in the expansion population and other uninsured workers would enroll in private plans and receive a different, minimum benefit package.

## Committee for Colorado Health Care Solutions Proposal Questions

### Question:

***Does the No Larimer County proposal raise ERISA issues?***

Answer:

Possibly. We modeled the proposal assuming there is no conflict with ERISA. One can not know for sure until it is tested in court.