The Financial Impact of Alternative Health Reform Plans in New Mexico

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New Mexico

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I. INTRODUCTION

The New Mexico Health Policy Commission has developed two alternative health reform plans that would achieve universal coverage by 1998. The first alternative is a single-payer plan in which all New Mexico residents would obtain coverage through a single state operated health insurance plan. The second alternative is a multi-payer plan where individuals would chose from a selection of health plans competing on the basis of price and quality. Both reform plans would require employers to contribute to the cost of covering workers and their dependents and both include taxes to cover other program costs.

In this report, we analyze the financial impact of these alternative reform plans on various payers for health care including state, local, and federal governments. In addition, we present estimates of the financial impact of these proposals on employers by industry and firm size. We also estimated the financial impact of alternative variations in benefits and financing under these reform plans. Finally, we present estimates of the impact of a voluntary insurance coverage program which could serve as an incremental first step towards universal coverage.

Our analysis is presented in the following sections:

- Summary of universal coverage plans;
- Estimating the impact of health reform in New Mexico;
- New Mexico health spending under reform;
- Government spending under reform;
- Changes in employer health spending;
- Impact on household health spending;
- Variations in plan design; and
- Voluntary coverage expansions.

In addition, detailed analysis tables for the single payer and multi-payer proposals are presented in ***Appendices A and B***.

II. Overview Of Alternative Health Reform Plans In New Mexico

New Mexico House Bill 702 directed the state Health Policy Commission to develop alternative models of health care delivery and payment to support universal health coverage for New Mexicans by October 1, 1997. In accordance with the state legislation, the Commission chose to consider two alternative models: (1) a single payer approach which would create a statewide, publicly funded health care system administered by a state agency; and (2) a multi-payer approach based on managed competition and financed through premium payments. Limits on the rate of growth in health spending could be implemented through either program.

In this study, we estimated the financial impact of the two alternatives on the state government and other payers for health care including: employers of various firm size and industry groups; households of various age and income groups; and federal and local governments. As originally specified by the New Mexico Health Policy Commission, the single payer and multi-payer models included different standard benefits packages and different approaches toward cost controls. To make the two alternatives as comparable as possible, our analysis assumes identical benefits packages for both models and cost control provisions under each alternative. Variations on these assumptions are examined latter in this analysis.

This section summarizes the two policy alternatives in the following sections:

- Single Payer Model
- Multi-Payer Model
- Treatment of Medicare Beneficiaries
- Differences in Financing

Exhibit 1 illustrates the structure of the single payer model and compares it to the multi-payer alternative.

A. Single Payer Model

The single payer model studied in this analysis would replace the current health insurance system in Mew Mexico with publicly financed coverage under a new state Commission. All New Mexicans (except Medicare recipients) would be covered under the state health plan with a standard benefits package. Inherent in the single payer model is the seamless integration of the Native American population into the new state-run health plan. All New Mexicans would receive coverage under this system, and services would be provided through a uniform program without any regard to race, or economic status.

EXHIBIT 1
OVERALL STRUCTURE OF SINGLE AND MULTI-PAYER MODELS COMPARED

	Single Payer	Managed Competition
Insurer	One government health plan for all state residents except Medicare	Competing health insurance plans for all state residents except Medicare
Delivery System	Fee-for-Service Medicine	Capitated payments to integrated health plans
Benefits	President Clinton's benefits package: hospital care; physician services; drugs; mental health up to limits	
Patient Cost Sharing	Patient deductible of $200; 20 percent copayment; $1,500 out-of-pocket limit ($3,000 per family)	
Medicare Population	Medicare retained; state provides: supplemental drug coverage; out-of-pocket maximum	
Employer Financing	Payroll tax of 7.92 percent	Premium for workers and dependents ($1998) Individual = $1,757 Couple = $3,514 Two-Parent = $4,696 One-Parent = $2,967
Employer/Employee Shares	Employer pays 80 percent/employee pays 20 percent	
Non-Workers	No premium	Pays full premium
Family Premium Subsidies	None Required	No premium below poverty; sliding scale through 200 percent of poverty
Employer Premium Subsidy	None Required	Cap on employer spending: 7.9 percent of payroll
Cost Sharing Subsidies	No cost sharing for persons below poverty	
Tax on Family Taxable Income	2.08 percent of taxable income	2.78 percent of taxable income

Although publicly financed coverage means that families would no longer pay health insurance premiums, the single payer model would require some level of cost sharing. Individuals with incomes over 100 percent of poverty would be responsible for: a $200 annual deductible ($400 per family) and 20 percent coinsurance above the deductible up to a $1,500 out-of-pocket limit ($3,000 per family). Persons below the federal poverty line are exempt from all cost sharing requirements. Exempting this population from cost sharing implicitly establishes a system of cost sharing subsidies financed by the state.

Financing for the single payer alternative would come from two general sources: (1) funding from current public sector health spending; and (2) dedicated payroll and personal income taxes. Current public sector health spending includes Medicaid (federal, state, and disproportionate share hospital funds) and funding for other health programs (including the Indian Health Service). With Native Americans completely integrated into the new system, Indian Health Service funds could be used to offset the costs of providing health care to this population.

The employer payroll tax rate would be set at a level sufficient to cover program costs for workers and dependents. Based on our analysis of costs under the program, we estimate that the payroll tax rate would be 7.92 percent. Costs for non-workers would not be financed through the payroll tax. Employers and employees both would pay a portion of payroll tax expenses, 80 percent and 20 percent respectively. We also assume that the tax rate on personal taxable income, 2.08 percent, is set at a level sufficient to cover all remaining program costs.

Because the single payer system is tax financed, there would be no premium requirements for families or employers, nor would there be premium subsidy requirements placed on the state. However, exempting persons below poverty from cost sharing does entail a system of cost sharing subsidies that would be part of a single payer system.

Finally, the single payer model includes a number of cost containment mechanisms, including:

- An overall health care budget limiting expenditures for covered services;
- Negotiated fee schedules for health professional reimbursement;
- Global budgets for health care facilities;
- Utilization management;
- Administrative cost caps; and
- A statewide formulary.

B. Multi-Payer Model

Like the single payer model, the multi-payer model is designed to provide universal coverage for all New Mexicans. However, unlike the tax financed single-payer plan, the multi-payer model relies on a combined employer/individual mandate and premium subsidies under a managed competition system to achieve its goal.

Under the multi-payer model, all employers would be required to provide insurance coverage for workers employed more than 20 hours per week. Employers would pay 80 percent of the cost of a standard premium based on the weighted average cost of coverage in the region. Employees would pay the remaining 20 percent of premium costs.

Along with the employer/individual mandate, the multi-payer model would implement premium subsidies to help businesses and families finance the cost of insurance. Employed persons with incomes up to 100 percent of poverty would be eligible for full premium subsidies for their share of insurance costs. Subsidies would be phased-out for persons with incomes through 200 percent of poverty.

In addition, the multi-payer model would require all non-working individuals (except Medicare beneficiaries) to purchase insurance coverage. Non-workers with incomes below 100 percent of poverty would be eligible for full premium subsidies up to the cost of a "standard" plan; premium subsidies would be phased-out for individuals and families through 200 percent of poverty.

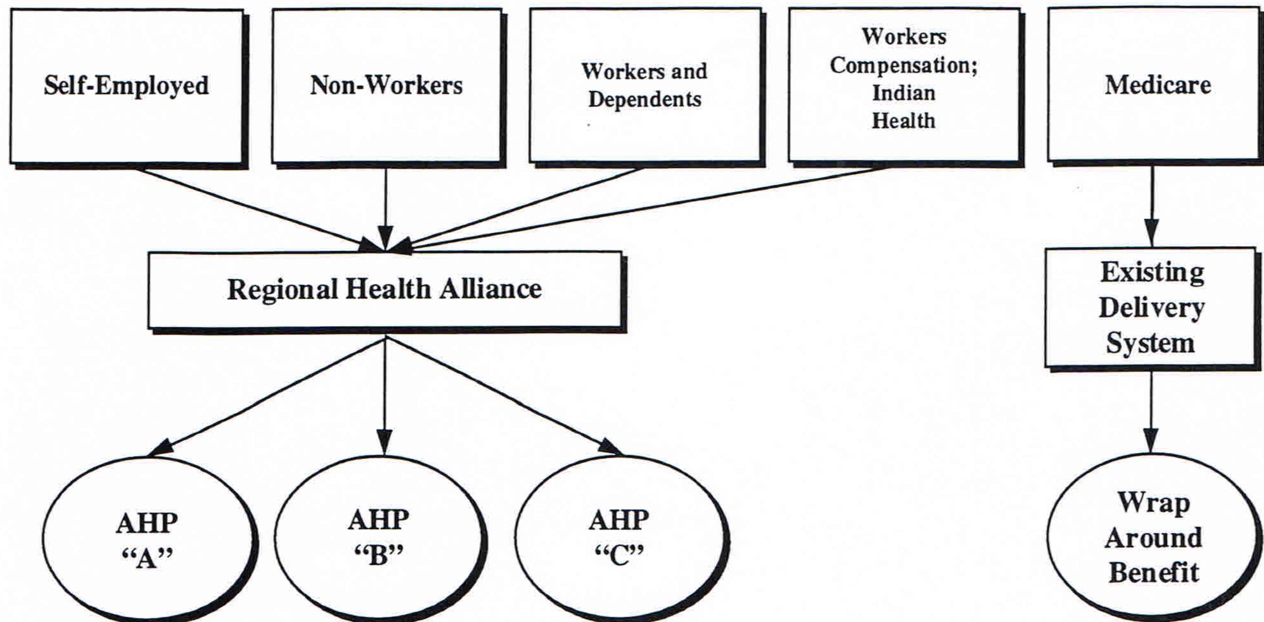
Employers also would be eligible for premium subsidies in the form of a premium cap for each employer. Under this policy, employers would be reimbursed by the state for premium expenses in excess of 7.9 percent of payroll. Thus, no employer will spend more than 7.9 percent of payroll on health insurance.

Like the single payer model, the multi-payer system includes patient cost sharing. This includes a $200 annual deductible ($400 per family) and 20 percent coinsurance above the deductible up to a $1,500 out-of-pocket limit ($3,000 per family). Families below 100 percent of poverty are exempt from cost sharing requirements. Like the single payer system, the multi-payer system would include a cost sharing subsidy system financed by the state to pay these costs for persons below poverty.

To facilitate businesses and individuals in purchasing coverage, the multi-payer model would establish Regional Health Alliances. All individuals and businesses, including those covered through workers compensation or Indian Health programs, would select from Approved Health Plans (AHPs) through the Alliance ***(Exhibit 2)***.

EXHIBIT 2

MANAGED COMPETITION: CONSUMERS CHOOSE FROM SEVERAL COMPETING HEALTH PLANS



Public subsidies and other costs under the multi-payer system would be financed through: (1) current state and federal spending for Medicaid and the Indian Health Service; and (2) a 2.78 percent tax on personal taxable income. As under the single-payer system, the tax rate on personal income is set at a level sufficient to fund program costs not covered by premiums and current government health spending.

The Native American population would be completely integrated into the multi-payer system just as under the single payer system. Native Americans would receive coverage in the same manner as any other New Mexican, either through an employer or through the Alliance. Native Americans would be eligible for the same premium and cost sharing subsidies as the rest of the population, and services would be provided without regard to race, ethnicity, or income.

The primary cost containment features under the multi-payer model are incentives for individuals to enroll in lower-cost health plans (i.e., managed competition). Employer premium contributions are tied to average costs in a region; if an employee chooses a plan with premium costs in excess of the regional average, the employee must pay more than the standard 20 percent share. In addition, premium subsidies are available only for the employees' 20 percent share of the average premium; costs in excess of this amount must be paid by employees.

As the managed competition system induces individuals to choose the lowest priced AHPs, health plans will have to reduce costs to remain competitive. The primary manner in which AHPs will reduce costs is through increased efficiency through increased use of managed care.

We assume that the multi-payer model would have the effect of moving more and more people into managed care settings which in turn would result in health care savings.

In addition, the multi-payer model could be implemented with a cap on the rate of growth in premiums. For comparison purposes, we assume that the multi-payer model is implemented with expenditure budgets which limit the growth in health care costs to the same levels permitted under the single-payer model.

C. Treatment of Medicare Beneficiaries

Under both the single-payer and the multi-payer programs, we assume that Medicare coverage is retained for all persons who are currently eligible for that program. The Medicare benefits package covers most hospital and physicians services but does not cover prescription drugs and does not include a maximum out-of-pocket spending limit. We assume, however, that under both health reform plans, additional benefits would be provided for Medicare beneficiaries.

Under both policy options, we assume that a program would be established to provide prescription drug benefits to persons who are covered under Medicare. In addition, the program would place a limit on out-of-pocket expenses for Medicare beneficiaries of $1,500 per individual and $3,000 per family. The program would be identical under both the multi-payer and the single-payer models.

D. Differences in Financing

Perhaps the most important distinction to make between the two alternatives addressed in this paper is the financing source. The single payer system is tax financed while the multi-payer system is premium financed. The tax financed system is directly tied to an individual's ability to pay for coverage. That is, family payments for health care are computed as a percentage of income which in effect varies family payment amounts by income level. In comparison, the premium paid by an individual in a premium financed system is unrelated to a persons income. Thus, the premium is the same for each individual regardless of income except among low-income groups where premium subsidies are provided.

Consequently, the premium financed multi-payer system must include a system of subsidies to make insurance affordable to low income families. The tax financed single payer system requires no premium subsidies because their tax payments are already varied for families by income level (i.e. ability to pay). However, both models must include cost sharing subsidies for persons below poverty.

III. ESTIMATING THE IMPACT OF HEALTH REFORM IN NEW MEXICO

In this analysis, we estimated the financial impact of the single payer and the multi-payer proposals on major payers for health care in New Mexico including state and local governments, employers, households and the federal government. In particular, we estimated the distributional impact of these proposals on various subgroups of these payer groups such as small employers and families in various age and income groups. These estimates were developed using the Lewin-VHI Health Benefits Simulation Model (HBSM) which is specifically designed to provide these detailed distributional impacts analyses for state-level health reform initiatives.

In this section, we describe the data and methods used in HBSM to develop estimates of these health reform initiatives in New Mexico. We begin by describing the overall methodology used in the model. We then explain how the model was adapted to provide New Mexico specific estimates of the impact of this bill on health spending by various payers in future years. The discussion is presented in the following sections:

- Overview of HBSM
- Health Spending in New Mexico
- Projections to Future Years

A. The Health Benefits Simulation Model

HBSM is a "microsimulation" model of health spending. The core of the model is a representative sample of New Mexico households. For each household in the sample these data provide information on health insurance coverage, health spending, income employment and basic demographic characteristics. The model uses these data to show how expenditures for households will change as they become covered under a new health insurance system. This micro level approach of simulating changes in spending for individual households permits us to estimate both the aggregate impact of major health reform initiatives as well as the impact on households of various socio-economic groups.

For example, the model estimates the increase in utilization which will occur as coverage is extended to previously uninsured persons. The model also determines which of the services for each individual are covered under the plan, the reimbursement amount for these services under the plan's cost sharing rules, and savings to the sources of payment for this care under current law (family out-of-pocket, employers, county hospitals, charity care, etc.). Because the model is based upon a representative sample of the population, it produces aggregate estimates of the impact of policy proposals on total number of persons affected, aggregate health spending, and program costs. However, because the model develops these estimates based upon analyses performed on an individual-by-individual basis, the model also provides estimates of the impact of these policies on various socioeconomic groups.

Using these data, HBSM produces estimates of program impacts by source of payment including:

- Employer Impacts
  - Number of workers and dependents affected
  - Cost to employers
  - Impact on firms that do not now insure
  - Number of firms affected
  - Uncompensated care cost shift savings
  - Tax savings (corporate deductions for health benefits, if applicable)

- Provider Impacts
  - Utilization by type of service/provider
  - Sources of payment for care
  - Expenditures for services by type of service/provider
  - Hospital uncompensated care

- Household Impacts
  - Number of insured by income, age, sex, etc.
  - Family premium payments
  - Family out-of-pocket spending

- Government Impacts
  - Expenditures under Medicaid expansions
  - Offsets to general assistance
  - Offsets to public hospitals
  - Corporate income tax losses
  - Tax revenues under various financing mechanisms

The basic data source used in this analysis is the New Mexico subsample of the March 1993 Current Population Survey (CPS) conducted by the Bureau of the Census. These data provide detailed information on New Mexico residents by age, income, employment status and other demographic characteristics

Because the CPS does not include health spending data, we merged the New Mexico subsample of the CPS with the 1987 National Medical Expenditures Survey (NMES) data which includes health care utilization and expenditures data for households across various income, age and employment status groups. The population and income data in the data base were adjusted to

1994 based upon the best available projections for that year. Health expenditures data were then controlled to replicate aggregate health expenditures estimates for 1994 by type of service and source of payment in New Mexico as estimated in a recent study by RAND.

The model also uses a survey of private employers in New Mexico developed by RAND. These data provide information on employer insurance coverage including firm size, industry, coverage, and employee premium contributions. The sample also includes employers that do and do not offer insurance. These data permit us to develop estimates of health spending impacts for workers and firms in various firms size and industry groups in New Mexico.

B. Health Spending in New Mexico

As discussed above, health spending in the household data base is controlled to replicate estimates of health spending by type of service and source of payment for New Mexico. Estimates of health spending in the state are based upon an analysis of New Mexico health spending by RAND ***(Exhibit 3)***. These estimates were derived from various sources, including HCFA data on health expenditures by type of service. Data provided by various government agencies on public program expenditures were also used.[1]

These data indicate that total expenditures for health care in New Mexico were $3.9 billion for the period July 1, 1992 through June 30, 1993. Expenditures for personal health services were $3.5 billion of which about $300 million was for long-term care services and $3.2 billion was for acute care services. State health spending included about $235 million for administration of public and private insurance programs and about 54 million in public health expenditures.

C. Projections Through 1998

The household data base was "aged" to be representative of the New Mexico state population in 1998. This was accomplished by adjusting the population totals in these data to reflect trends in population growth by age and sex. The earnings and other income data reported in the household data base were also adjusted to reflect income growth projection. Finally, health expenditures were adjusted to reflect projections of health spending by type of service and source of payment.

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[1] "Existing Health Care Delivery System, Estimated Fiscal Resources, State Health Expenditure For The Period July 1, 1992 through June 30, 1993," New Mexico Health Care Initiative, July 25, 1994.

Exhibit 3
Existing Health Care Delivery System Estimated Fiscal Resources State Health Expenditure
July 1, 1992 through June 30, 1993

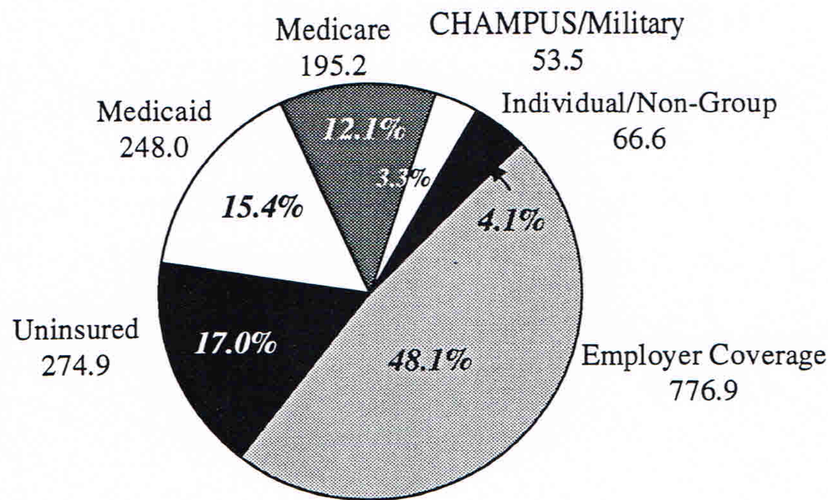
Description	All Private Funds	Private Consumer			Other	Government			Total
		Total	Out-of-Pocket	Claims Paid		State & Local	Federal	Total	
HEALTH SERVICES & SUPPLIES									
Hospital Care	$951,484.2	$902,958.5	$32,350.5	$870,608	$48,525.7	$314,917.2	$256,133.8	$571,051.0	$1,522,535.2
Physician Services	$732,702.3	$732,702.3	$135,135.9	$597,566.4	$0.0	---	---	$0.0	$732,702.3
Dental Services	$179,467.2	$179,467.2	$84,349.6	$95,117.6	$0.0	---	$6,843.0	$6,843.0	$186,310.2
Other Professional Services	$205,342.0	$205,342.0	$32,169.7	$173,172.3	$0.0	---	$10,211.2	$10,211.2	$215,555.2
Home Health Care	$68,519.3	$68,519.3	$14,389.1	$54,130.2	$0.0	---	---	$0.0	$66,619.3
Prescription Drugs & Non-Durable	$339,859.6	$339,859.6	$187,262.6	$152,597.0	$0.0	---	$3,689.5	$3,689.5	$343,549.1
Vision & other Durable	$60,196.8	$60,198.8	$60,198.8	N/A	$0.0	---	---	---	$60,198.8
Nursing Home Care	$209,474.5	$209,474.5	$90,283.5	$119,191.0	$0.0	$27,328.3	---	$27,328.3	$236,802.8
Other Personal Health Care	$0.0	---	---	---	$0.0	$121,019.5	$28,265.7	$149,285.2	$149,285.2
Total Personal Health Care	$2,747,047.9	$2,698,522.2	$636,139.7	$2,062,382.5	$48,525.7	$463,265.0	$305,143.2	$768,408.2	$3,515,456.1
PROGRAM ADMINISTRATION AND GOVERNMENT PUBLIC HEALTH									
Program Admin & Net Cost of Private Health Ins.	$217,819.6	---	---	---	$217,819.6	$18,645.4	---	$18,645.4	$236,465.0
Govt. Public Health Activities	$0.0	---	---	---	$0.0	$50,562.9	$3,345.4	$53,908.3	$53,908.3
Total Prog. Admin. & Govt. Public Health	$217,819.6	$0.0	$0.0	$0.0	$217,819.3	$68,208.3	$3,345.4	$72,553.7	$290,373.3
WIC, CCFP, AND ENVIRONMENTAL PROGRAMS									
WIC & CCFP	$0.0	---	---	---	$0.0	$52,446.8	---	$52,446.8	$52,446.8
Environmental Programs	$0.0	---	---	---	$0.0	$25,859.2	---	$25,859.2	$25,859.2
Total WIC, CCFP & Envir. Programs	$0.0	$0.0	$0.0	$0.0	$0.0	$78,306.6	$0.0	$78,306.0	$78,306.0
TOTAL HEALTH SERVICES & SUPPLIES	$2,964,867.5	$2,698,522.2	$636,139.7	$2,062,382.5	$2,66,345.3	$610,778.3	$308,488.6	$919,267.9	$3,884,135.4
RESEARCH & CONSTRUCTION									
Research	N/A	---	---	---	N/A	N/A	N/A	---	N/A
Construction	$45,098.0	---	---	---	$45,098.0	---	---	---	$45,098.0
TOTAL RESEARCH & CONSTRUCTION	$45,098.0	---	---	---	$45,098.0	---	---	---	$45,098.0
TOTAL STATE HEALTH ACCOUNT									
	$3,009,965.5	$2,598,522.2	$636,139.7	$2,062,382.5	$311,443.3	$610,779.3	$308,488.8	$919,287.9	$3,929,233.4

Source: New Mexico State Health Expenditure (SHE) account.

The population totals were adjusted to reflect Bureau of the Census projections of population levels by age and sex in New Mexico through 2000. These estimates show that the New Mexico population is growing faster than the general population in the United States. We also adjusted the Medicaid coverage data to reflect federally mandated expansions in coverage for children through 1998, and expansions in coverage for children to 185 percent of poverty recently enacted by the New Mexico state legislature. Projections of the New Mexico population by primary source of insurance are presented in ***Exhibit 4***.

EXHIBIT 4

DISTRIBUTION OF NEW MEXICANS BY PRIMARY SOURCE OF INSURANCE COVERAGE IN 1998
(IN THOUSANDS)
(AVERAGE MONTHLY COVERAGE ESTIMATES)



NUMBER OF PERSONS: 1,615.1

Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

As discussed above, we adjusted the incomes reported by individuals in the data base to future years. Earnings were adjusted based upon historical data on real growth in earnings per worker. Non-earnings income were projected based upon the historical rate of growth in non-earnings income per person. These growth estimates were adjusted to be consistent with national income projections provided by the Congressional Budget Office (CBO).

Health expenditures were adjusted to future years based upon projections of the growth in per-capita health spending by type of service provided by the Congressional Budget Office.[2] These expenditure growth rates were adjusted to reflect the fact that health expenditures in New

2 "Projections of National Health Expenditures: 1993 Update," Congressional Budget Office, October 1993.

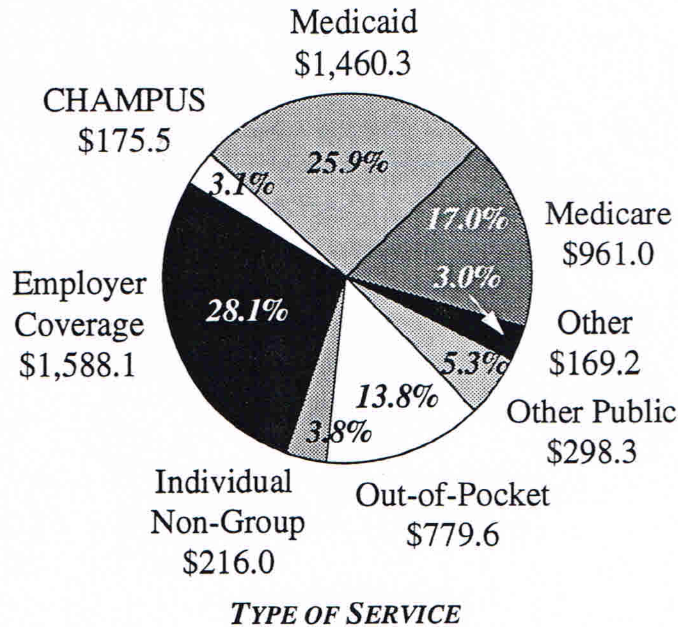
Mexico have historically grown more slowly than the national average. Our projections of health spending in New Mexico are summarized in ***Exhibit 5*** for 1994 through 2000.

The methods used to project expenditures to 1998 include:

- **Hospital Spending:** HCFA provides estimates of trends in aggregate hospital revenues through 1991. We projected the 1992 estimates to 1998 based upon these trends in New Mexico.
- **Physician Spending:** HCFA provides estimates of trends in physician revenues in New Mexico through 1991. We projected physician revenues to 1998 based upon these historical trends in New Mexico physician revenues.
- **Prescription Drug Spending:** HCFA provides estimates of trends in prescription drugs expenditures through 1991 for New Mexico. The 1991 estimate was projected to 1998 based upon these historical trends in prescription drug expenditures in New Mexico.
- **Other Health Services:** Data on trends in spending for other health services are not available for New Mexico. We projected spending for other health services in New Mexico based upon national trends adjusted to reflect state population growth.

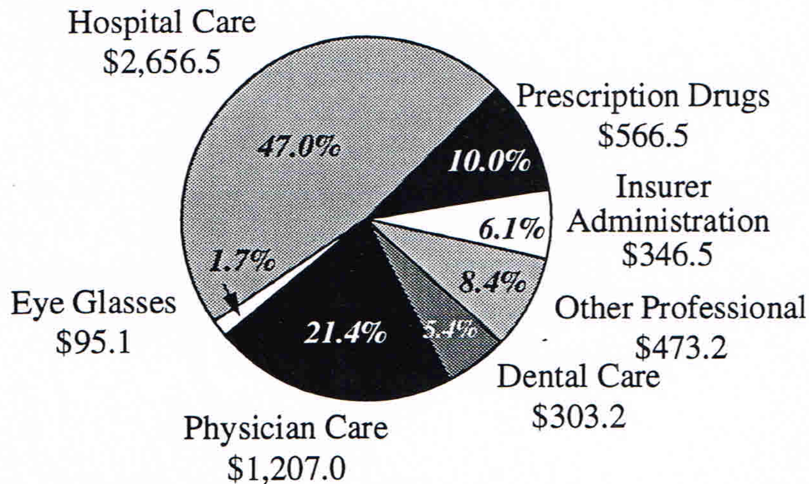
EXHIBIT 5
HEALTH SPENDING IN NEW MEXICO BY SOURCE OF PAYMENT AND TYPE OF SERVICE IN 1998

SOURCE OF PAYMENT



TYPE OF SERVICE

TYPE OF SERVICE



TOTAL HEALTH EXPENDITURES = $5,648.0 MILLION

a Excludes research, construction, public health and long-term care.

IV. Changes in Aggregate health Spending Under the Act

As discussed above, we estimate that total spending for personal health care services would be about $5.7 billion in 1998. This includes total spending for acute care services only in such as benefits payments to hospitals and physicians and insurer administration. This estimate excludes spending for public health, long-term care, research, and construction. In this analysis we estimated the change in overall spending for acute care health services in New Mexico under the single payer and multi-payer proposals over the 1995 through 2004 period. We estimated the change in provider revenues under the Act as well as changes in spending for major payers for health care including employers, households and governments.

Our analysis of the impact of the Act on health spending in New Mexico is presented in the following sections:

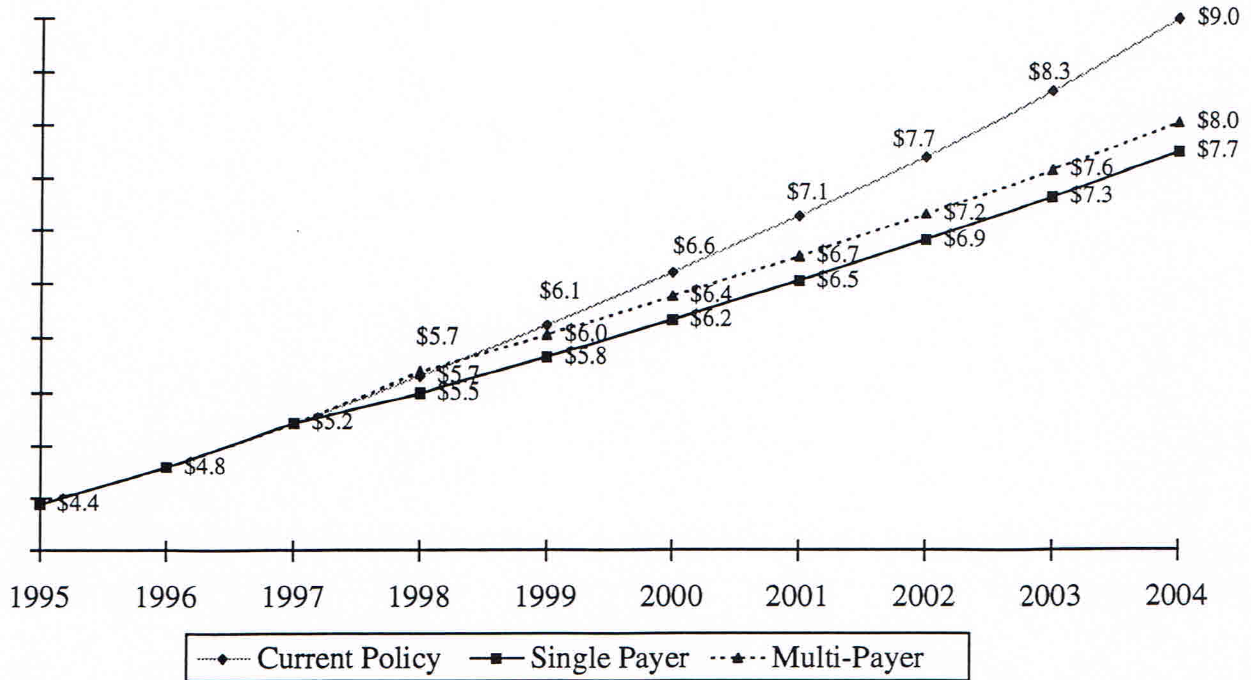
- Changes in Aggregated Health Spending Under the Act
- Sources of Changes in Health Spending
- Sources and Uses of Funds under Universal Coverage Plans
- Health Spending by Major Payers for Care

A. Health Spending Over Time Under the Act

We estimate that health spending in New Mexico will increase from $3.5 billion in 1993 to $6.6 billion in 2000 under current policy ***(Exhibit 6)***. We assume that under both the single payer and the multi-payer reform plans, the state would set limits on the rate of growth in health spending in New Mexico which would be enforced through controls on provider reimbursement and limits on private insurer premium increases. Under Both proposals, health spending will eventually fall below levels projected under current policy after 1998 as the effect of the health expenditure caps increases over time. Overall health spending in New Mexico will decrease by $4.4 billion over the 1998 through 2004 period under the single payer plan and $2.9 billion under the multi-payer plan.

EXHIBIT 6

TOTAL HEALTH SPENDING IN NEW MEXICO UNDER CURRENT POLICY AND ALTERNATIVE REFORM PLANS (IN BILLIONS)



Under both of these programs, cost controls would be the primary source of savings. Potential savings over this period under the single payer program are about $1.5 billion greater than under the multi-payer program primarily due to the lower cost of administration under a single-payer system. While the multi-payer plan is more costly than the single payer model, it emphasizes managed care practices which potentially eliminate unnecessary care and improve the quality of care provided. Moreover, the multi-payer model provides a choice of health plans which could enhance overall consumer satisfaction with the health care system.

These estimates are vitally dependent upon the effectiveness of cost controls under the program. The cost control mechanisms under these programs are largely untested in the United States and may not immediately prove effective. Moreover, the health expenditure budgeting process is sure to be a highly political process that may not always yield results that are consistent with the goals of cost containment. The broad rights of due process guaranteed under the United States Constitution may also affect spending through legal appeals of reimbursement policies. However, because the program is tax financed, the state is likely to be at least partially effective in slowing the increase in spending to avoid tax rate increases.

B. Sources of Changes in Health Spending

In this analysis, we assume that these health reform plans would first be implemented in 1998. We estimate that total health spending in New Mexico would decline by about $151.8 million under the single payer model while health spending would increase by about $43.7 million under the multi-payer model ***(Exhibit 7)***. Under both reform plans, utilization of health services will increase by about $207.6 million as coverage is extended to the uninsured. However, this increase in utilization will be more than offset by administrative savings of $359.4 million under the single-payer model.

Administrative costs would actually increase by about $47 million under the multi-player model as all New Mexico residents become covered under private insurance. However, much of these added costs will be offset by managed care savings of $256.6 million due to the emphasis on managed care in the multi-payer model. Thus, the multi-payer model would result in a net increase in health spending of $43.7 million in 1998 after all of these effects are taken into consideration.

EXHIBIT 7

CHANGES IN HEALTH SPENDING IN NEW MEXICO UNDER ALTERNATIVE HEALTH REFORM PLANS IN 1998 (IN MILLIONS)[a]

	Single Payer	Multi-Payer
CHANGES IN HEALTH SERVICES UTILIZATION		
Increase in Utilization Due to Expanded Coverage:	$207.6	($49.0)
Utilization Increase for Previously Uninsured[b]	$158.2	$158.2
Expanded Coverage for Those Already Insured[c]	$49.4	$49.4
Managed Care Savings	----	($256.6)
CHANGE IN ADMINISTRATIVE COST		
Insurer Administration (Includes Administration for Newly Insured)[d]	($181.3)	$47.3
Provider Administrative Savings[e]	($211.7)	($11.0)
Administration of Cost Sharing Subsidies	$33.6	$56.4
Net Change in Administrative Costs	**($359.4)**	**$92.7**
NET CHANGE IN HEALTH SPENDING		
Net Change in Health Spending	**($151.8)**	**$43.7**

a Includes spending for acute care services only; excludes spending for long-term care, public health, research and construction.

b Assumes that utilization of health services by previously uninsured persons will rise to the levels reported by insured persons with similar age, sex, income and health status characteristics.

c Assumes that utilization of newly covered health services for insured persons whose coverage is upgraded (prescription drugs, etc.) will rise to the levels reported by persons who have such coverage.

d Reflects the reduced insurer administrative cost of covering all persons under a single payer program.

e Reflects the reduced provider administrative cost due to a single payer program.

Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

These changes in spending are summarized in the following sections:

- Health services utilization
- Administrative savings under the single payer plan
- Managed care savings under the managed competition plan
- Expenditure limits.

1. Health Services Utilization

Under both health reform alternatives, health services utilization in New Mexico would increase as comprehensive health care coverage is extended to all individuals. In particular, increased utilization is expected among the 275,000 persons who would otherwise be uninsured in 1998. Utilization is also expected to increase among persons whose coverage is improved under these reforms.

We estimate that previously uninsured persons will consume about $450 million in health services in 1998. This includes expenditures incurred in public indigent care programs, uncompensated care and out-of-pocket spending for these individuals. We assume that under a program of universal insurance coverage, use of health services for this population would increase to levels reported by insured persons with similar age, sex, income and self-reported health status characteristics. The net increase in health spending for previously uninsured persons would be about $158 million.

There also will be an increase in utilization for previously underinsured persons. Many insured individuals do not have coverage for some of the services that would be covered under the uniform benefits package. In particular, many plans do not cover prescription drugs, psychiatric services, and dental care. We assume that utilization of these services will increase to levels reported by persons who have coverage for these services with similar age, sex, income and health status characteristics. The net increase in spending for the underinsured would be $49.4 million in 1998.

2. Administrative Savings Under the Single Payer Plan

The single payer system streamlines health care administration by centralizing the source of payment for all covered health services under a single governmental program with uniform coverage and reimbursement rules. The 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. Thus, eliminating the complexity of diverse insurer rules and billing practices. These potential savings are partly offset by the cost of administering cost controls and other functions performed by the health commission.

We estimate that insurer administrative costs in New Mexico will be $346 million in 1998 under current law. This includes $251.8 million for administration of private insurance and $94.7 million for administration of public programs. The cost of insurance administration includes the cost of processing claims, research, utilization review, and determining eligibility under government programs. Administrative overhead for private insures also includes marketing costs, taxes, net reserve accumulations and profits.

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, transitions in coverage, and maintaining the administratively cumbersome linkage between employers and insures. Overall, statewide insurer administrative costs would be reduced from $346.5 million under current policy to $181.3 million under the single payer model for a net savings of $165.2 million in 1998.

We estimate that about 32 percent of physician and other professional revenues ($516.1 million) will be devoted to administrative functions in 1998. Physician administrative costs include all physician overhead expenditures attributed to activities other than those directly related to patient care such as business office staff and the value of physician time devoted to practice management and insurer-related functions. The single payer approach would substantially reduce claims-filing costs for physicians by standardizing the means of 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. We estimate that physician administrative costs would be reduced by about 21 percent ($108.1 million) in 1998 under the single payer model.

Our analysis indicates that New Mexico hospitals will spend about $887.3 million (33.4 percent of revenues) on administration in 1998. In this analysis, we define hospital administrative costs to include all labor and overhead expenditures attributed to functions other than those directly related to patient care, such as accounting, credit and collections, and admitting. The single payer proposal would reduce hospital administrative costs associated with filing claims and selective contracting negotiations. Hospital administrative costs would be reduced by about 12 percent ($103.6 billion) in 1998 under the single payer model.

3. *Managed Care Savings Under the Multi-Payer Proposal*

We estimate that a multi-payer model with competing health plans will result in managed care savings of about $256.6 million in 1998. We estimated these savings based upon a comparison of utilization and health expenditures under group model Health Maintenance Organizations (HMOs), Independent Practice Association (IPA) HMOs (i.e., network HMOs), and fee-for-service (FFS) plans. We assume that under the multi-payer model, people would be able to choose among a variety of health plans with differing levels of effectiveness in controlling

utilization. We assume that savings under these plans will be consistent with the overall average savings achieved by the current mix of all types of HMO plans .

Our estimates of managed care savings are based upon two recent Lewin-VHI studies, one developed using 1989 National Health Interview Survey (HIS) data and the other using data from three major insurance companies, Aetna, Humana, and Prudential.[3,4] The analysis of HIS data allowed us to estimate savings from staff and group model HMOs. The analysis of insurer data was used to estimate savings in IPA models.

Our analysis indicates that inpatient utilization is lower for HMOs and IPAs as compared to FFS plans. For persons under age 65, participants in group model HMOs use about 19 percent fewer hospital days compared to FFS patients. IPA members showed 14 percent less use of hospital days. Overall, managed care accounts for 16.5 percent fewer hospitals days (***Exhibit 8***). Lower inpatient utilization is possible because HMOs and IPAs provide a greater portion of care in less costly, outpatient settings. We estimate that group HMO members use 6.6 percent more physicians visits than FFS enrollees while IPA members use 1.4 percent more physician visits.

EXHIBIT 8
MANAGED CARE UTILIZATION ADJUSTED FOR AGE, SEX, AND HEALTH STATUS FOR PERSONS UNDER AGE 65

		Group Model HMO[a]		IPA Model HMO[b]		All HMOs	
	Fee-For-Service	Amount	Percent Difference	Amount	Percent Difference	Amount	Percent Difference
Hospital Days (per 1,000)	419	338	(19.0%)	360	(14.1%)	350	(16.5%)
Physicians Visits (per capia)	3.35	3.57	6.6%	3.30	1.4%	3.48%	4.0%

a Regression estimates for a population standardized as to age, sex, self-reported health status, education, family income, geographic area, and urban rural status based upon analysis of the 1989 national Health Interview Survey Health Insurance Supplement data.

b regression estimates based upon insurer data for IPA HMOs and managed fee for service plans.

Source: Lewin-VHI, Inc.

4. Health Expenditure Limits

In this analysis, we assumed that both of these bills would impose limits on the rate of growth in health expenditures. Under both bills, we assume that total health spending would be capped so that expenditures increase at roughly the rate of growth in gross domestic product (GDP) plus an allowance for population growth. These expenditure growth limits would be enforced through limits on provider fees and caps on the rate of growth in insurer premiums.

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[3] Lewin-ICF, "Effects of Managed Care, Uninsurance and AIDS on Health Care Use," report to the Health Resources and Services Administration, Washington, D.C., 16 July 1992.

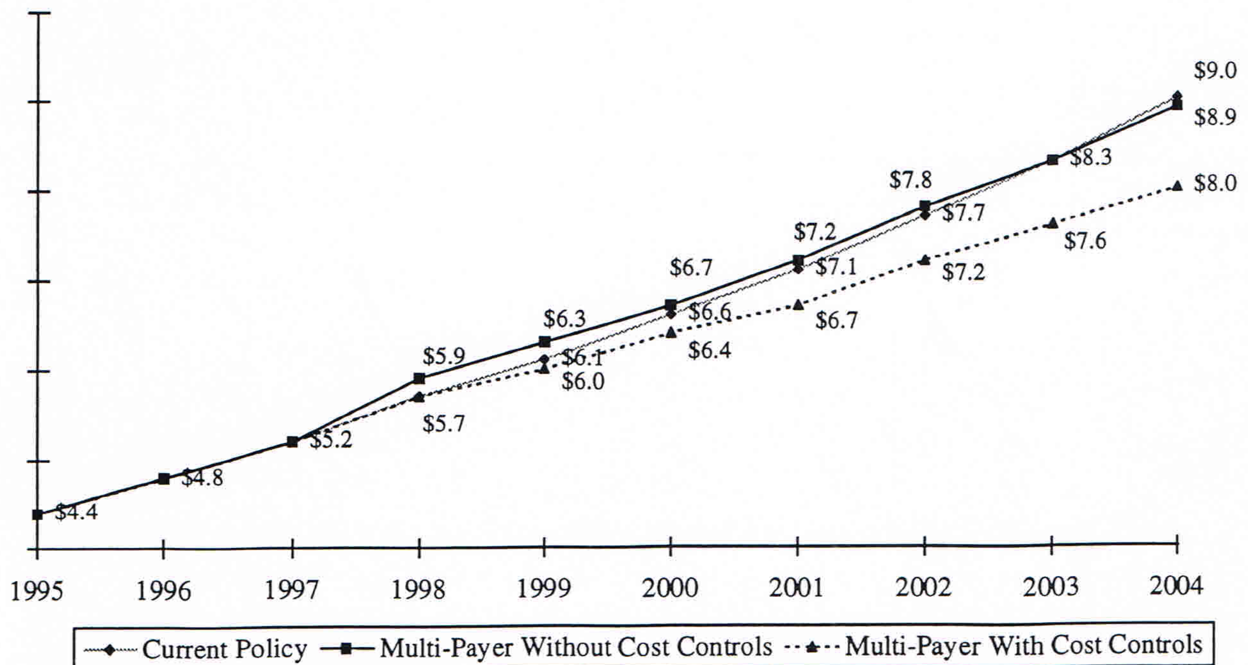
[4] David Stapleton, "New Evidence on Savings From Network Models of Managed Care," Lewin-VHI, May 5, 1994.

We assume that per-capita GDP growth in New Mexico will be the dame as the growth in national per-capita GDP as projected by the Congressional Budget Office. We also assume that these cost controls are fully effective in controlling the rate of growth in spending. These estimates implicitly assume that health expenditure budgets are reduced to reflect provider savings in administration and uncompensated care expenses. For example. provider administrative savings would not translate into a reduction in health spending unless provider payments are reduced to reflect these savings. Similarly, reductions in uncompensated care expenses will result in a windfall to providers unless provider payment rates -- which typically include an implicit overhead charge for uncompensated care expenses -- are adjusted for the elimination of these expenses under a program of universal coverage.

In the absence of these expenditure controls. health spending under these reform plans would be substantially greater than sown above. Also, without price controls, it would not be possible to pre-empt windfall increases to providers through reduced uncompensated care and reduced provider administrative burdens. However, the multi-payer model is likely to reduce the rate of growth in health spending due to price competition among health plans. Based upon an analysis of premium growth in plans with and without managed care indicates that managed care plans slow the annual rate of growth in premiums by about seven-tenths of one percent. ***Exhibit 9*** presents estimates of aggregate health spending under the multi-payer model with and without controls on health spending.

EXHIBIT 9

TOTAL HEALTH SPENDING IN NEW MEXICO UNDER THE MULTI-PAYER PROGRAM WITH AND WITHOUT COST CONTROLS



C. Sources And Uses Of Funds For Universal Coverage Plans

Both plans would provide a uniform set of benefits to all New Mexico residents not otherwise covered under Medicare. In addition, both programs would provide Medicare recipients with prescription drug benefits and catastrophic protection. Although the benefits provided would be the same under both plans, these plans differ in administration, use of managed care and sources of revenues.

Total program expenditures under the single payer plan would be $3.6 billion in 1998, net of administrative savings. Expenditures under the multi-payer plan net of managed care savings would be $3.8 billion ***(Exhibit 10)***. In fact, single payer program expenditures would be about $180.8 million less than multi-payer program costs largely due to the administrative savings under the single payer plan.

Both programs would in part be funded with revenues for existing government insurance programs that would be absorbed into the universal coverage program. The single payer program also would be funded with a payroll tax on employers and employees while the multi-payer program would be funded with premium payments by employers and families. Under both programs, additional revenues would be raised through a tax on family taxable income which is sufficient to fully fund the program. Total personal income tax revenues required in 1998 would be $447.0 million under the single payer model and $581.4 million under the multi-payer model.

D. Health Spending By Major Payer

The Act would substantially change aggregate health spending for governments, employers, and households. For example, we estimate that overall health spending in New Mexico would increase by $151.8 million in 1998 under the single payer plan. Private employer health spending also would increase by $131.0 million reflecting increased payroll tax payments as coverage for CHAMPUS/Military beneficiaries is shifted to the single payer program. Household health spending would decrease by $124.3 million due to the elimination of premium payments and reduced out-of-pocket spending ***(Exhibit 11)***.

However, empirical research indicates that most of the increased costs to employers resulting from the payroll tax would be passed-on to employees in the form of reduced wages. This wage loss would offset health expenditure savings for households resulting in a net increase in spending for households of $61.5 million. We also estimate that the state and federal governments would lose substantial amounts of personal income tax revenue as wages are reduced.

Exhibit 12 shows the change in spending for major payers for care under the multi-payer proposal. The impact of the Act on major payers for health care is discussed in greater detail in the following sections.

EXHIBIT 10

SOURCES AND USES OF FUNDS UNDER ALTERNATIVE HEALTH REFORM PLANS COMPARED IN 1998

	Single Payer	Multi-Payer
PROGRAM EXPENDITURES		
Benefit Payments	$3,638.2	$3,819.0
Coverage for General Population[a]	$2,912.8	$2,856.9
Medicare Supplemental Benefits[b]	$598.1	$598.1
Insurer Administration[c]	$127.3	$364.0
PROGRAM REVENUES		
Current Program Funding	$1,596.3	$1,600.4
Medicaid[d]	$1,121.5	$1,121.5
Indian Health and Other	$336.9	$336.9
Other Public Funds[e]	$137.9	$142.0
Employer Payments	$1,276.9	$1,022.5
Premium/Payroll Tax Payments	$1,276.9	$1,180.8
Employer Premium Subsidy	----	($158.3)
Family Payments	$765.0	$1,196.1
Worker Premium/Payroll Tax	$318.0	$296.7
Non-Worker Premium	----	$1,342.6
Premium Subsidies	----	($1,024.6)
Personal Income Tax	$447.0	$581.4
Total Program Revenues	$3,638.2	$3,819.0
NET PROGRAM COST		
Net Program Cost	$0.0	$0.0

a Includes payments to providers for health services covered under the standard benefits package for all persons in New Mexico except those covered under Medicare. Reflects managed care savings and adjustments for provider administrative savings. Includes cost sharing subsidies provided under the program. Does not include supplemental coverage for employed population.

b Includes prescription drug coverage for Medicare recipients and wrap around coverage to limit family out-of-pocket spending for the Medicare population.

c Includes the cost of insurer administration and the cost of administering premium and cost sharing subsidies under the program.

d Includes state and federal shares of Medicaid funding for all services except long-term care.

e Includes other state program funding less the amount of the net increase in state employee health benefits costs and lost tax revenues due to mandated contributions.

Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

EXHIBIT 11

CHANGES IN HEALTH SPENDING IN NEW MEXICO UNDER A SINGLE PAYER MODEL IN 1998 (IN MILLIONS)[a]

	Before Wage Effects		After Wage Effects	
CHANGES IN HEALTH SPENDING				
Federal Government Health Spending		($137.2)		($90.0)
Employee Benefits Costs	$32.7		$32.7	
CHAMPUS Program	($169.9)		($169.9)	
Tax Loss (Gain)	----		$47.2	
State Government Health Spending		($8.2)		$0.0
Total Program Costs	$3,681.0		$3,681.0	
Program Revenues	($3,689.2)		($3,689.2)	
Tax Loss (Gain)	----		$8.2	
County Government Health Spending		($13.1)		($13.1)
Savings to Indigent Care Program	($29.2)		($29.2)	
Local Government Worker Health Benefits	$16.1		$16.1	
Private Employer Health Spending (Net of Subsidies)		$131.0		($110.2)
Firms That Now Insure	($62.0)		----	
Workers and Dependents	$48.2		----	
Retirees	($110.2)		($110.2)	
Firms That Do Not Now Insure	$193.0		----	
Household Health Spending		($124.3)		$61.5
Premium Payments	($649.4)		($649.4)	
Payroll Tax Payments	$765.0		$765.0	
Out-of-Pocket Payments	($239.9)		($239.9)	
After-Tax Wage Loss (Gain)	---		$185.8	
NET CHANGE IN HEALTH SPENDING				
Net Change in Spending[a]		($151.8)		($151.8)

a See Exhibit 7 for a detailed summary of changes in national health spending.

Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

EXHIBIT 12

CHANGES IN HEALTH SPENDING IN NEW MEXICO UNDER A MULTI-PAYER MODEL IN 1998 (IN MILLIONS)[a]

	Before Wage Effects		After Wage Effects	
CHANGES IN HEALTH SPENDING				
Federal Government Health Spending		($180.3)		($127.3)
Change in CHAMPUS Funding	($169.9)		($169.9)	
Employee Benefits Costs	($10.4)		($10.4)	
Tax Loss (Gain)	----		$53.0	
State Government Health Spending		($6.1)		$0.0
Total Program Costs	$2,222.6		$2,222.6	
Program Revenues	($2,228.7)		($2,228.7)	
Tax Loss (Gain)	----		$6.1	
Local Government Health Spending		($21.2)		($21.2)
Savings to Indigent Care Programs	($29.2)		($29.2)	
Local Government Worker Health Benefits	$8.0		$8.0	
Private Employer Health Spending (Net of Subsidies)		$95.7		($107.7)
Firms That Now Insure	($65.8)		($107.7)	
Workers & Dependents	$41.9		----	
Retirees	($107.7)		($107.7)	
Firms That Do Not Now Insure	$161.5		---	
Household Health Spending		$155.6		$299.9
Premiums Payments	($85.0)		($85.0)	
Out-of-Pocket Payments	($340.8)		($340.8)	
Personal Income Tax	$581.4		$581.4	
After-Tax Wage Loss	---		$144.3	
NET CHANGE IN HEALTH SPENDING				
Net Change in Health Spending[a]		$43.7		$43.7

a See Exhibit 7 for a detailed summary of changes in national health spending.

Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

V. GOVERNMENT SPENDING UNDER HEALTH REFORM

Both the single payer and the multi-payer health reform proposals would have significant implications for health spending by all levels of government including the state government, local governments and the federal government. These include expenditures for indigent care programs and various tax effects. The impact of the Act on government finances is discussed in the following sections:

- State Program Expenditures
- Local Government Spending
- Federal Government Expenditures

A. State Program Expenditures

Both health reform plans will result in a net increase in state government health spending. Under the multi-payer option the state would finance various subsidies for families and employers while under the single payer plan, all health spending for covered services would flow through the state treasury. State finances under these reform plans are discussed below.

1. Single Payer

Total state government expenditures under the single payer program would be $3.7 billion in 1998 ***(Exhibit 13)***. This includes benefits payments, cost sharing subsidies and administrative costs. The total state cost of administering the single payer program would be $127.3 million in 1998. Programs expenditures include:

- **Benefits Costs:** Includes estimated provider payments and insurer administrative costs offset by an adjustment in provider payment rates to reflect: 1) the value of free care that becomes reimbursable which is currently paid for through the cost shift; and 2) the value of provider administrative savings.
- **Medicare Wrap Around Benefits:** Medicare beneficiaries would receive a wrap around benefit that includes prescription drugs and a $1,500 out-of-pocket limit.
- **Supplemental Benefits:** Supplemental benefits will be provided to Medicaid recipients for currently covered services that are not covered under the standard benefits package.
- **Cost Sharing Subsidies:** Subsidies will be provided for out-of-pocket costs for persons below poverty.
- **Tax Loss:** The Payroll tax will result in a net loss of wages with a corresponding reduction in state personal income tax revenues.
- **State Employee Benefits:** Reflects the net change in state employee health care costs resulting from a shift to the payroll tax.

EXHIBIT 13

NEW MEXICO STATE PROGRAM COSTS UNDER THE SINGLE PAYER MODEL IN 1998 (IN MILLIONS)

PROGRAM COSTS		
New Program Costs[a]		$2,692.7
Payments for Acute Care	$2,964.0	
Administration	$93.7	
Offsets		
Uncompensated Care Savings	($153.3)	
Provider Administrative Savings	($211.7)	
Wrap Around Benefit for Medicare Beneficiaries[b]		$598.1
Supplement Services[c]		$205.6
Cost Sharing Subsidies[d]		$141.8
Subsidy Payments to Individuals	$108.2	
Administration of Subsidies	$33.6	
Tax Loss (Gain) Due to Payroll Tax[e]		$8.2
State Employee Benefits[f]		$42.8
Total Program Cost		**$3,689.2**
PROGRAM FINANCING		
Funding for Current Medicaid (Acute Care Only)[g]		$1,121.5
State Share	$291.6	
Federal Share	$829.9	
Payroll Tax		$2,041.9
Employer Share	$1,276.9	
Employee Share	$318.0	
Personal Income Tax	$447.0	
Federal Funding Transfer to Program[h]		$336.9
State General Funding Transfer to Program		$188.9
Total Program Funding		**$3,689.2**
NET PROGRAM COSTS		
Net Revenue Requirement		($0.0)

a Includes estimated provider payments and insurer administrative costs offset by an adjustment in provider payment rates to reflect: 1) the value of free care that becomes reimbursable which is currently paid for through the cost shift and 2) the value of provider administrative savings.

b Medicare beneficiaries will receive a wrap around benefit that includes prescription drugs and a $1,500 out-of-pocket limit.

c Supplemental benefits will be provided to Medicaid recipients for currently covered services that are not covered under the standard benefits package.

d Subsidies will be provided for out-of-pocket costs for persons below poverty.

e The payroll tax will result in a net loss of wages with a corresponding reduction in state personal income tax revenues.

f Reflects the net change in state employee health care costs resulting from a shift to the payroll tax.

g Includes Medicaid funding for acute care services.

h Includes funding for the Indian Health Service and other federal funds.

Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

Revenues under the program would include the payroll tax and funding for existing government programs that would be absorbed into the program. This includes state and federal Medicaid funding for acute care ($1.1 billion), federal funding for Indian health Service and other programs ($336.9 million) and state general funding for indigent care and mental health services ($188.9 million). Payroll tax revenues would be $2.0 billion in 1998. An additional $447.0 million would be collected in personal income taxes to fund the balance of the program.

2. *Multi-Payer Model*

Total state program expenditures under the multi-payer program would be $2.2 billion in 1998 ***(Exhibit 14)***. This includes premium subsidy payments to families and employers as well as Medicare supplemental benefits. Total administrative costs under the program would be $56.4 million. These program expenditures include:

- **Family Premium Subsidies:** Premium subsidies are provided for families through 200 percent of poverty.
- **Cost Sharing Subsidies:** Cost sharing subsides are provided for families below 100 percent of poverty.
- **Employer Subsidies:** Employer premium payments are capped not to exceed 7.9 percent of employee payroll.
- **State Employee Benefits:** Includes the cost of upgrading state employee benefits and premium contributions to the minimum standard and the cost of insuring workers who are currently excluded from coverage under the program offset by cost shift and other savings.
- **Supplemental Benefits:** Benefits currently provided to Medicaid recipients that are not covered under the basic benefits package will continue as supplemental benefits.
- **Tax Loss:** The employer mandate will result in a net loss of wages with a corresponding reduction in state personal income tax revenues.
- **Medicare Wrap Around Benefits:** Medicare beneficiaries would receive a wrap around benefit that includes prescription drugs and a $1,500 out-of-pocket limit.

Program revenues would include funding for existing programs that would be absorbed into the multi-payer program and additional personal income tax revenues. These include funding for Medicaid ($1.1 billion), federal funding for the Indian Health Service and other programs ($336.9 million), and state funding for current indigent care and mental health programs.

EXHIBIT 14

NEW MEXICO STATE PROGRAM COSTS UNDER THE MULTI-PAYER MODEL IN 1998 (IN MILLIONS)

PROGRAM COSTS		
Family Subsidies		$1,132.8
Premium Subsidies[a]	$1,024.6	
Cost-Sharing Subsidies[b]	$108.2	
Medicare Wrap Around Benefit		$598.1
Employer Premium Subsidies[c]		$158.3
New State Employee Health Benefits[d]		$40.8
Supplemental Benefits[e]		$236.2
Tax Loss(Gain) Due to Mandate[f]		$6.1
Premium Subsidies Administration		$56.4
Total Program Costs		**$2,228.7**
PROGRAM FINANCING		
Funding for Current Medicaid		$1,121.5
State Share	$291.6	
Federal Share	$829.9	
Federal Funding Transferred to Program[g]		$336.9
State General Funding Transferred to Program		$188.9
Personal Income Tax Revenue		$581.4
Total Program Funding		**$2,228.7**
NET PROGRAM COSTS		
Net Revenue Requirement		($0.0)

a Premium subsidies are provided for families through 200 percent of poverty.

b Cost sharing subsidies are provided for families below 100 percent of poverty.

c Employer premium payments are capped not to exceed 7.9 percent of employee payroll.

d Includes the cost of upgrading state employee benefits and premium contributions to the minimum standard and the cost of insuring workers who are currently excluded from coverage under the program offset by cost shift and other savings.

e Benefits currently provided to Medicaid recipients that are not covered under the basic benefits package will continue as supplemental benefits.

f The employer mandate will result in a net loss of wages with a corresponding reduction in state personal income tax revenues.

g Includes funding for Indian Health Service and other Federal spending for personal health care in the state.

Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

B. Local Government Health Care Costs

Local governments generally would see savings under both the single-payer and the multi-payer health reform proposals. Local governments would save about $29.2 million in spending for existing county indigent care programs as all New Mexico residents become insured ***(Exhibit 15)***. These savings would be partly offset by increased spending for employee health benefits in local governments that currently do not insure all of their workers. Overall, local governments would see net savings of $13.1 million under the single payer proposals and $21.2 million under the multi-payer proposal.

EXHIBIT 15

CHANGE IN LOCAL GOVERNMENT HEALTH CARE COSTS UNDER ALTERNATIVE REFORM PROPOSALS IN NEW MEXICO IN 1998 (IN MILLIONS)

	Single Payer Proposal	Multi-Payer Proposal
Local Government Employee Health Benefits[a]	$16.1[a]	$8.0[b]
Local Government Indigent Care Programs[b]	($29.2)	($29.2)
Net Change in Local Government Health Spending	**($13.1)**	**($21.2)**

a Includes the reduction in employee and retiree health benefits offset by the payroll tax to finance the single payer program.

b Includes the cost of upgrading state employee benefits and premium contributions to the minimum standard and the cost of insuring workers who are currently excluded from coverage under the program offset by cost shift and other savings.

c County direct appropriations to hospitals are assumed to be reduced as coverage is extended to all persons in New Mexico.

Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

C. Federal Health Spending

The federal government also would see significant savings under both health reform models. Under both plans, the federal government would save about $169.9 million as beneficiaries in the CHAMPUS/Military program become covered under these plans ***(Exhibit 16)***. These savings would be partly offset by a loss of federal income tax revenues as employers adjust wage levels in response to increased employer health benefits costs. There will also be changes in federal employee health spending due to changes in employer contribution requirements under these bills. Net savings to the federal government would be $90.0 million under the single payer model and $127.3 million under the multi-payer model.

EXHIBIT 16

CHANGE IN FEDERAL HEALTH SPENDING UNDER ALTERNATIVE REFORM PROPOSALS IN 1998 (IN MILLIONS)

	Single Payer Proposal	Multi-Payer Proposal
Federal Employee Health Spending	$32.7[a]	($10.4)[b]
CHAMPUS Program	($169.9)	($169.9)
Federal Tax Revenue Loss(Gain)[c]	$47.2	$53.0
Net Change in Federal Spending	**($90.0)**	**($127.3)**

a Includes the reduction in employee and retiree health benefits offset by the employer share of the payroll tax.

b Includes reduction in federal worker health benefits as working dependent spouses of federal workers take coverage on their own job.

c Tax loss due to reduced wage levels resulting from higher employer costs.

Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

VI. EMPLOYER HEALTH SPENDING

Private employers would be one of the primary sources of financing for both health reform plans. Under the single payer plan, current employer health benefits obligations would be replaced with a tax computed as a percentage of payroll. Under the multi-payer plan current employer spending is replaced with a standardized premium contribution. The net impact of these changes in financing for individual employers will vary depending upon the degree to which individual employers currently insure their workers and employee wage levels. The impact of these reform initiatives on employer health spending is discussed in the following section:

- Impact on Total Private Employer Spending
- Impact on Employer Spending by Type of Firm
- Distributional Impacts on Employers
- Wage and Job Effects

A. Impact on Total Private Employer Spending

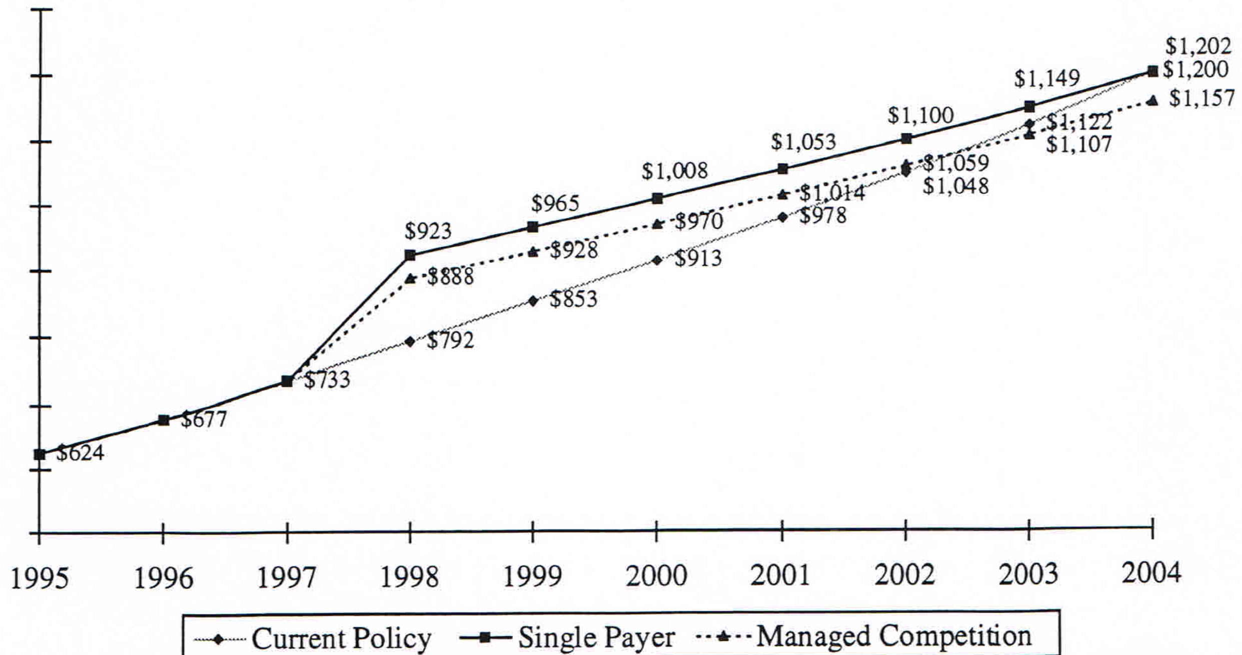
Under current law, we estimated that private employer health spending in New Mexico will grow from $624 million in 1995 to $913 million by 2000 ***(Exhibit 17)***. Under the multi-payer model, employers would spend an additional $96.0 million for health care in 1998. Under the single payer model, employer costs would increase by $131.0 million in 1998. Under both plans, employer costs would grow at a slower rate in subsequent years due to health spending controls.

The impact of health reform on employers will differ for workers and retirees. Private employers will spend about $791.8 million on health benefits in 1998 under current trends. This includes coverage for workers and dependents ($597.9 million), retiree coverage ($128.5 million) and the medical component of workers compensation ($65.4 million).

Employer spending for workers and dependents would increase by $304.2 million under the single-payer model and $265.6 million under the multi-payer model ***(Exhibit 18)***. Under both reform plans, these increases in employer spending would, in part, be offset by reduced workers compensation payments, ($62.2 million) as the medical component of that program is absorbed into basic insurance coverage. Spending for retirees will also decline due to the wrap-around coverage for Medicare recipients provided under the program. Some of these savings will accrue to out-of-state employers with retirees who reside in New Mexico.

Exhibit 17

Private Employer Health Spending Under Current Policy and Alternative Reform Plans: 1995-2004 (in millions)



Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

Exhibit 18

The Impact of Alternative Reform Plans on Private Employer Health Spending in New Mexico in 1998 (in millions)

	Current Spending	Change in Private Employer Spending: Single Payer Proposal	Change in Private Employer Spending: Multi-Payer Proposal
Workers and Dependents a/	$597.9	$304.2	$265.6
Retirees	$128.5	($110.2)	($107.7)
Workers Compensation (Medical component) b/	$65.4	($62.2)	($62.2)
Total	**$791.8**	**$131.8**	**$95.7**

a/ Includes premiums and/or payroll taxes for workers.

b/ Employers will see reduced workers compensation premiums as benefits become covered under the reform plan.

Source: Lewin-VHI estimates using the New Mexico version the Health Benefits Simulation Model (HBSM).

B. Impact on Employer Spending By Type of Firm

Under both proposals, private employers who now offer insurance will on average see savings under these health reform plans, largely due to the retiree savings. Firms that now offer insurance would save about $62.0 million under the single payer model and about $65.8 million under the multi-payer model ***(Exhibit 19)***. By comparison, firms that do not now offer insurance would pay about $1.1 billion for health care under the single-payer plan and $880 million under the multi-payer plan.

Much of the increase in private employer health spending would be concentrated among small firms, many of whom do not now offer insurance. Much of this added cost would be in the retail trade and services industries.

C. Distributional Impacts on Employers

The impact of reform on individual employers would vary depending upon employee wage levels and the extent to which they already provide comprehensive insurance coverage. For example, under the single payer proposal, even among businesses that now provide insurance, some would pay substantially more than they do now in cases where they have highly compensated workers. Conversely, insuring firms with lower wage workers will often find that the payroll tax payment will be less than they now pay for employee health benefits.

We estimate that about 45 percent of all employers who now offer insurance would see a reduction in health spending of $100 or more per employee under the single payer plan ***(Exhibit 20)***. On the other hand, about 50 percent of insuring employers would see an increase in health spending of $100 or more per employee. About 5 percent of employers who now offer coverage would see a change of less than $100 per employee. Under the multi-payer plan, 57.1 percent of firms will see reductions of $100 or more per worker and 35 percent will see increases of $100 or more per workers.

EXHIBIT 19

IMPACT OF ALTERNATIVE HEALTH REFORM PLANS ON PRIVATE EMPLOYERS IN NEW MEXICO BY FIRM SIZE IN 1998

	Net Change in Health Spending			
	Single Payer		Multi-Payer	
	Total (millions)	Avg. Change Per Worker	Total (millions)	Avg. Change Per Worker
PRIVATE EMPLOYERS BY FIRM SIZE				
1-9	$164.3	$924	$60.3	$339
10-24	$35.4	$662	$32.3	$603
25-99	$40.4	$570	$31.8	$448
100-499	$1.7	$35	$50.8	$1,050
500-999	($7.0)	($571)	($8.7)	($715)
1,000-5,000	($22.1)	($481)	($10.7)	($232)
5,000 or More	($81.7)	($1,178)	($60.1)	($864)
PRIVATE EMPLOYERS BY INDUSTRY				
Construction	$26.6	$658	$7.0	$173
Manufacturing	($81.7)	($1,832)	($23.0)	($517)
Transportation, Communication and Utilities	($8.6)	($270)	$1.7	$55
Wholesale Trade	($5.5)	($448)	($4.6)	($365)
Retail Trade	$75.2	$632	$47.2	$397
Services	$88.6	$512	$53.6	$309
Finance	$20.3	$785	$4.7	$190
Other	$16.1	$517	$9.1	$291
CURRENT INSURING STATUS				
Currently Provide Insurance	($62.0)	($210)	($65.8)	($222)
Do Not Now Provide Insurance	$193.0	$1,055	$161.5	$883
Total Private	**$131.0**	**$274**	**$95.7**	**$200**

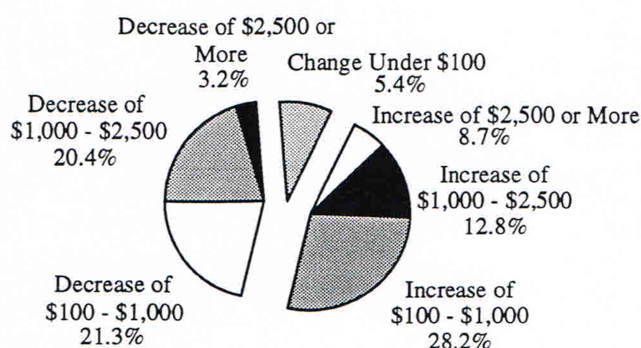
Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

EXHIBIT 20

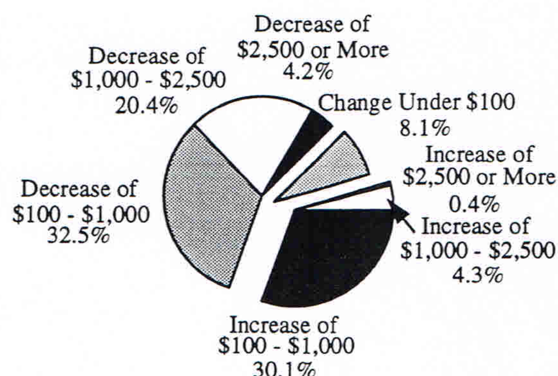
PRIVATE EMPLOYERS IN NEW MEXICO WHO NOW OFFER INSURANCE BY CHANGE IN SPENDING PER WORKER UNDER THE SINGLE PAYER PROPOSAL IN 1998[a]

	SINGLE PAYER PROPOSAL	MULTI-PAYER PROPOSAL
Increase of $100 or More per Worker	49.7%	34.8%
Change of Less than $100	5.4%	8.1%
Decrease of $100 or More per Worker	44.9%	57.1%

Single Payer Proposal



Multi-Payer Proposal



PRIVATE FIRMS OFFERING INSURANCE = 11,436

Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

D. Wage and Job Effects

Empirical evidence indicates that employers are likely to pass on much of the increase in employer costs to employees in the form of reduced wages and lost jobs.[5] Employer are typically limited in what they can charge in the market place necessitating changes in other compensation costs as employer payroll taxes are imposed. The economic literature indicates that much of the cost of increased health care spending has historically been passed on to workers.[6]

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

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

Based upon a review of the literature, we assume that 88 percent of the change in employer's cost due to the payroll tax will result in changes in wages to employees.[7] Conversely, in firms that see net savings under reform most of these savings are likely to result in wage increases as labor markets force adjustments to overall employee compensation packages in response to these changes in employer health benefits costs. We estimate a net reduction in wages of $212.2 million under the single payer proposals and $179.0 million under the multi-payer plan.

Some job loss is likely to occur among low-wage workers. The federal minimum wage law prohibits employers from adjusting wages downward for the very lowest wage workers. Consequently, employers are likely to adjust to the higher cost of lower wage employees by hiring fewer low wage workers, failing to replace low wage workers who leave through normal turnover, and laying off some workers immediately.

We base our estimates of potential job loss on two estimates of the labor demand elasticity which allows us to establish a conservative range for estimating job loss.[8] Under the tax rates in the bill, we estimate a potential loss of between 2,208 and 5,219 jobs ***(Exhibit 21)***. Under the single payer proposal, fewer than 1,000 jobs would be lost. This reflects the fact that health care costs for low-wage workers under the single payer proposal will be small because employer payments for these employer payments for these individuals are computed as a percentage of payroll.

EXHIBIT 21

POTENTIAL WAGE AND EMPLOYMENT EFFECTS UNDER ALTERNATIVE HEALTH REFORM PLANS IN 1996

	Single Payer	Managed Competition
Potential Wage Loss	$212.3 million	$179.0 million
Potential Job Loss	343-860	2,208-5,219

Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

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[7] This estimate is consistent with estimate found in the literature. For example, Gruber and Kreuger, op. cit., find that about 85 percent of the costs of mandated worker's compensation benefits are shifted to employees in the form of reduced wages, while Gruber, op. cit., found that virtually all of the employer's cost of mandated maternity benefits are shifted to the employee.

[8] See, for example, Charles Brown, Curtis Gilroy, and Andrew Kohen, "The Effects of the Minimum Wage on Employment and Unemployment, " Journal of Economic Literature, June 1982; and Brown Gilroy and Kohen, "Time Series Evidence of the Effect of the Minimum Wage on Youth Employment," Journal of Human Resources, Winter, 1983. More recent evidence is summarized in Jacob Klerman and Dana Goldman, "Job Loss Due to Health Care Reform," (RAND Corporation) Statement prepared for the Subcommittee on Health of the House Committee on Ways and Means, November 4, 1993.

Under the single payer plan, some jobs would also be lost in administrative occupations such as insurance workers and health care provider administrative staff. However, we expect that most of these workers would be reabsorbed by the labor market as savings in health spending are directed to other consumer goods. Moreover, there will be an increase in demand for health care providers that would offset the loss of employment in administration.

VII. IMPACT ON HOUSEHOLDS

Both of these health reform plans would have a significant impact on household health spending. Household spending would increase by $61.5 million under the single payer proposal and $299.9 million under the multi-payer plan ***(Exhibit 22)***. This includes increased family tax payments and wage loss net of premium reductions and reductions in family out-of-pocket payments for health services.

Overall, health spending for New Mexico households would increase by about $99 per family under the single payer model and $484 per family under the multi-payer plan ***(Exhibit 23)***. Under both proposals, lower income households would on average see net savings while higher income groups would see a net increase in health care costs. This reflected the use of relatively progressive tax policies to fund government expenditures under these reform plans.

The net impact of these reform plans on individual households will vary depending upon their current level of health spending, the extent to which they now have health coverage and their income. In general, households with little or no health coverage and/or high out-of-pocket costs would tend to benefit under reform. Conversely, many persons who now have comprehensive coverage would see a net increase in spending as New Mexico adopts tax financing for programs under the bill. Moreover, by shifting to an income related tax to finance health care, higher income persons will tend to pay more while lower income persons will tend to pay less. Thus, there will be extensive variability in the net impact on households.

Under both reform plans, over 30 percent of households would see a net increase in health spending of $1,000 or more ***(Exhibits 24 and 25)***. By Contrast, over 25 percent of households would see a net reduction in spending of $1,000 or more.

EXHIBIT 22
IMPACT OF MANAGED COMPETITION ON HOUSEHOLDS IN NEW MEXICO IN 1998 (IN MILLIONS)

	Single Payer Proposal		Multi-Payer Proposal	
PRIVATE PREMIUM PAYMENTS				
Family Premium Payments		($491.0)		($27.5)
Current Family Premium Payments[a]	($680.1)		($680.1)	
Premium Obligations Under Act	$189.1		$1,677.2	
Premium Subsidies[b]	----		($1,024.6)	
DIRECT PAYMENTS FOR CARE				
Direct Payments[c]		($340.8)		($340.8)
AUTOMOBILE INSURANCE AND OTHER PREMIUMS				
Other Insurance Payments		($57.5)		($57.5)
AFTER TAX WAGE EFFECTS				
After-Tax Wage Loss Under of Mandate (counted as added household cost)[d]		$185.8		$144.3
TAX PAYMENTS				
Tax Payments		$765.0		$581.4
Personal Income Tax	$447.0		$581.4	
Employee Share of Payroll Tax	$318.0		----	
NET CHANGE IN HOUSEHOLD SPENDING				
Net Impact on Household Spending		$61.5		$299.9

a Includes employee premium contributions and premiums for individually purchased non-group coverage.

b Premium subsidies are provided to individuals below 200 percent of poverty.

c Family out-of-pocket payments for health services will be reduced under the program due to: 1) reduced patient cost-sharing requirements under the plan; 2) expanded coverage for services often excluded under existing plans; and 3) cost sharing subsidies for persons below poverty.

d Employers are assumed to pass-on the cost of insurance in the form of reduced wages.

Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

EXHIBIT 23
AVERAGE CHANGE IN HEALTH SPENDING PER FAMILY UNDER REFORM PLANS IN NEW MEXICO BY INCOME IN 1998

			Average Change in Household Spending	
	Number of Families (in thousands)	Average Household Spending Under Current Policy[a]	Single Payer	Managed Competition
Less than $10,000	132.0	$1,059	($389)	($650)
$10,000 - $14,999	60.0	$2,081	($530)	($512)
$15,000 - $19,999	45.0	$2,769	($482)	($21)
$20,000 - $29,999	96.5	$2,633	($284)	$518
$30,000 - $39,999	60.5	$3,113	($293)	$726
$40,000 - $49,999	49.7	$3,390	($234)	$726
$50,000 - $74,999	95.9	$3,561	$64	$909
$75,000 - $99,999	38.1	$3,852	$940	$1,626
$100,000 or more	41.3	$4,237	$3,756	$3,159
All Families	**619.0**	**$2,684**	**$99**	**$484**

a Includes premiums and direct payments for acute care services only.

b Includes changes in premiums, out-of-pocket expenses, taxes earmarked to fund health reform, and after-tax changes in wages resulting from employer funding requirements.

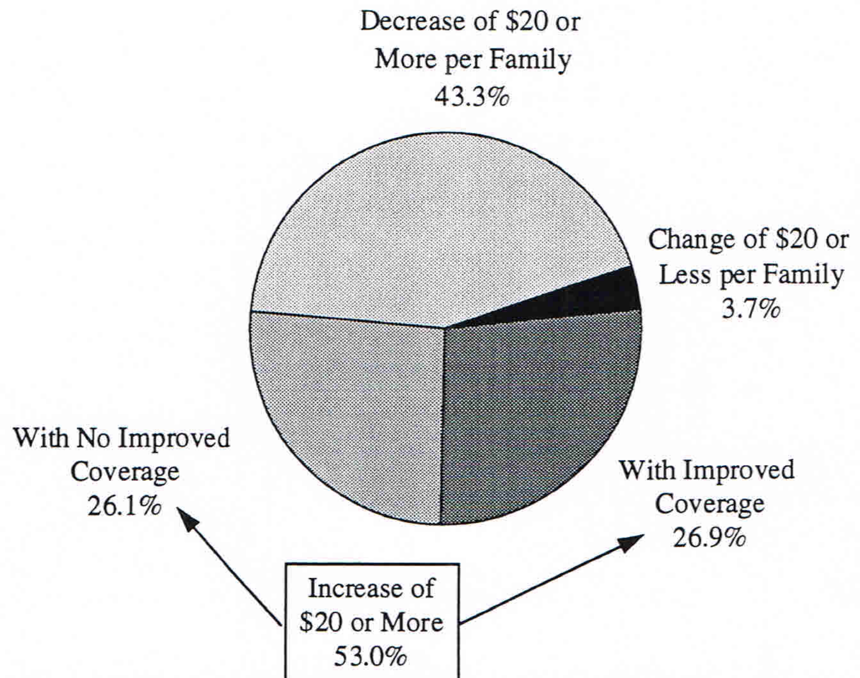
Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

EXHIBIT 24

DISTRIBUTION OF FAMILIES IN NEW MEXICO BY CHANGE IN HOUSEHOLD HEALTH SPENDING UNDER A SINGLE PAYER MODEL IN 1998[a]

Families Whose Spending Would Decrease By:	
$1,000 or More	28.3%
$500-$1,000	7.7%
$250-$500	3.5%
$100-$250	2.4%
$20-$100	1.4%

Families Whose Spending Would Increase By:	
$1,000 or More	30.0%
$500-$1,000	11.1%
$250-$500	5.7%
$100-$250	3.8%
$20-$100	2.4%



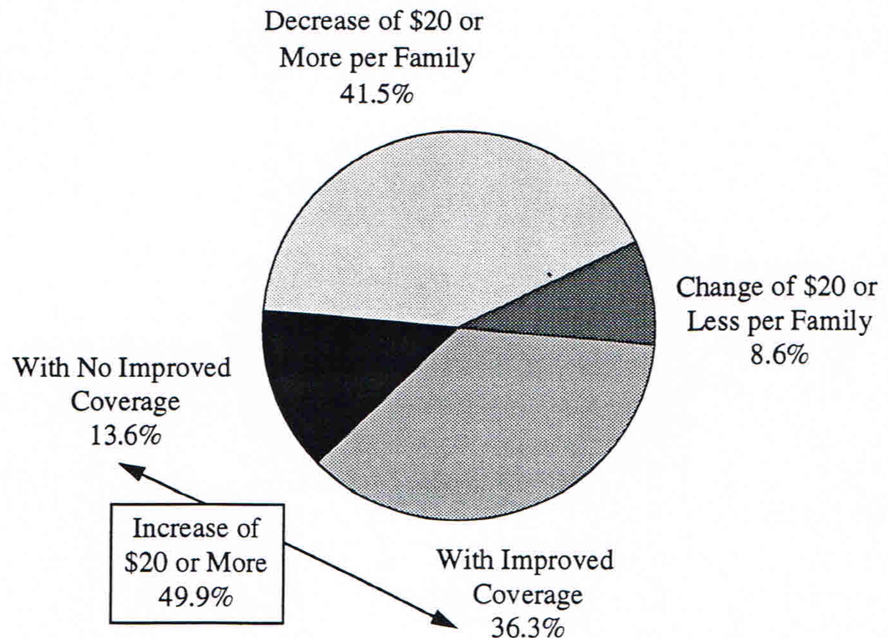
a Includes changes in premiums, out-of-pocket expenses, taxes earmarked to fund health reform and wage effects. Excludes institutionalized persons. Includes acute care services only.

EXHIBIT 25

DISTRIBUTION OF FAMILIES IN NEW MEXICO BY CHANGE IN HOUSEHOLD HEALTH SPENDING UNDER MANAGED COMPETITION IN 1998[a]

Families Whose Spending Would Decrease By:	
$1,000 or More	25.8%
$500-$1,000	7.5%
$250-$500	4.0%
$100-$250	2.4%
$20-$100	1.8%

Families Whose Spending Would Increase By:	
$1,000 or More	31.5%
$500-$1,000	8.2%
$250-$500	4.5%
$100-$250	3.2%
$20-$100	2.5%



a Includes changes in premiums, out-of-pocket expenses, taxes earmarked to fund health reform and wage effects. Excludes institutionalized persons.

Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

VIII. VARIATIONS IN PROGRAM DESIGN

The financial impact of the health reform plans discussed above will vary with program design. Program costs could be either reduced or increased by altering the basic benefits provided under these reforms. The impact of these reforms on employers and households could be altered by changing employer contribution requirements under these bills. To illustrate, we examined three variations in program design, including:

- Adding long-term care coverage
- Reducing the employer contribution requirement
- Eliminating patient cost sharing

A. Long-Term Care Coverage

In the analysis presented above, we assumed that the same benefits package is provided under both the single payer model and the multi-payer model. This benefit package covers acute care services such as hospital and physician care but does not cover long-term care. Under these reform plans, the current Medicaid program is maintained for long-term care services.

Long-term care coverage could be added to the program as an additional benefit. The program would serve as a separate wrap-around program for all New Mexico residents, and/or a supplement to the coverage provided under Medicare. Medicaid coverage for long-term care would be absorbed into the program.

In this analysis, we estimated the cost of implementing such a program in New Mexico. The program is modeled on the long-term care benefit that was included in the McDermott/Wellstone single payer proposal. The program would cover:

- Institutional and residential care including Alzheimer's disease units (room and board covered only for persons with limited resources)
- Home health care
- Hospice care
- Home and community-based services, including personal assistance and attendant care

The program would cost about $498.0 million in 1998. These new programs cost would be partly offset by savings to the Medicaid program of $199 million so that the net cost of the program would be $299 million. This amount could be raised with a tax on personal income of 1.39 percent ***(Exhibit 26)***. Adding this coverage to the single-payer plan would increase the

personal income tax rate for that program to 3.47 percent. Adding this benefit to the multi-payer program would increase the personal income tax rate for that program to 4.17 percent.

EXHIBIT 26
TAX RATE ON PERSONAL TAXABLE INCOME REQUIRED TO FUND THE LONG-TERM CARE BENEFIT IN 1998

	Without Long-Term Care	With Long-Term Care
Current Policy	--	1.39%
Single Payer	2.08%	3.47%
Multi-Payer	2.78%	4.17%

Source: Lewin-VHI estimates.

B. Employer Contributions

The impact of reform on employers could be minimized by reducing the employer share of contributions under the program. In the multi-payer model analyzed above, employers are required to pay at least 80 percent of the premium. Similarly, employers are required to pay 80 percent of the payroll tax under the single-payer program. To show the sensitivity of our estimates to this specification we re-estimated the impact of these reforms on employer costs assuming that the employer share is reduced to 50 percent under both programs.

This change in contribution rates would tend to reduce employer costs while increasing household health spending. For example, under the multi-payer model, employers would pay about $1.0 billion in premiums net of employer subsidies provided under the Act ***(Exhibit 27)***. If the employer contribution is reduced to 50 percent of the premium, employer costs would drop to $866 million. This change would increase employee contributions by $247 million. However, the personal income tax revenue requirements under the bill would drop from $581 million to $496 million, which reflects the fact that the lower employer premium contribution requirement would reduce employer premium subsidy payments under the Act.

Lowering the employer contribution requirement under the single payer model also would reduce employer costs while increasing employee tax payments. Employer costs under the single payer plan would be about $1.3 billion in 1998 if employers are required to pay 80 percent of the payroll tax. If the employer share is reduced to 50 percent, employer costs would drop to about $1.0 billion. However, employee tax payments would increase form $318 million to $585.3 million. ***Exhibit 28*** presents total employer health spending under both the multi-employer and single employer plans assuming a 50 percent employer contribution requirements.

EXHIBIT 27

SOURCES AND USES OF FUNDS UNDER ALTERNATIVE EMPLOYER CONTRIBUTION REQUIREMENTS UNDER HEALTH REFORM IN 1998

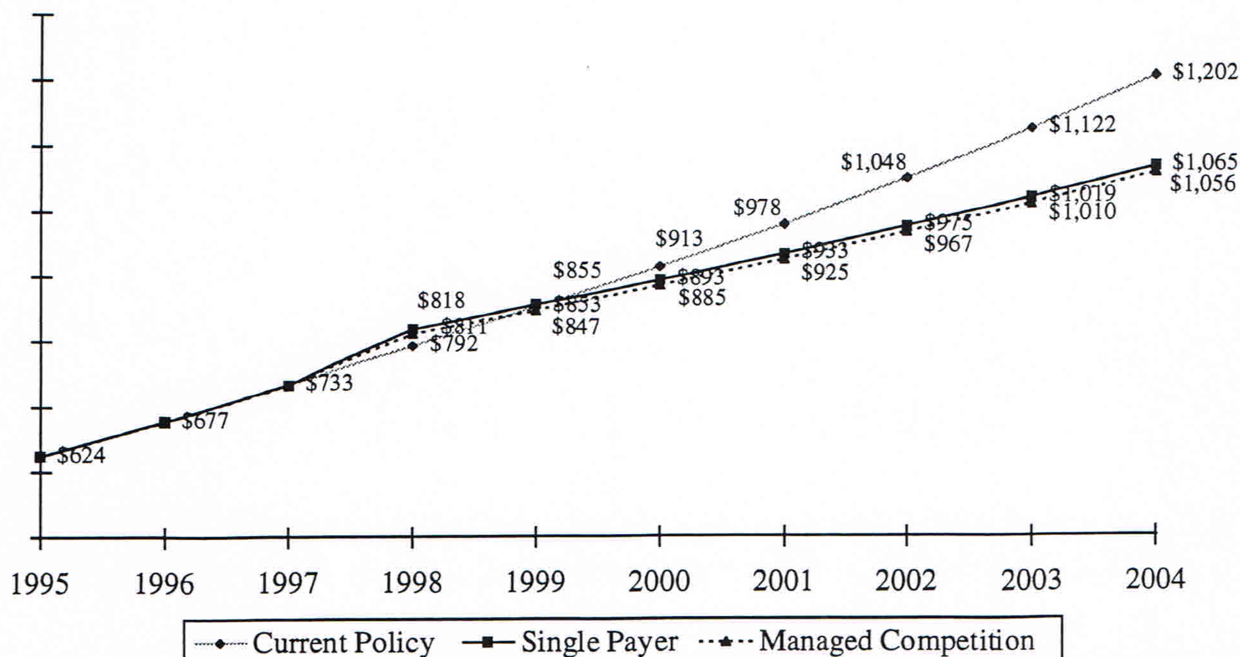
	Single Payer		Managed Competition	
	80 Percent Employer Share	50 Percent Employer Share	80 Percent Employer Share	50 Percent Employer Share
PROGRAM EXPENDITURES				
Benefits and Administration	$3,638.2	$3,638.2	$3,819.0	$3,819.0
PROGRAM REVENUES				
Current Public Program Funding (Net of Offsets)	$1,596.3	$1,631.0	$1,600.4	$1,635.9
Employer Payments	$1,276.9	$1,009.6	$1,022.5	$866.8
Premium/Payroll Tax	$1,276.9	$1,009.6	$1,180.8	$933.6
Employer Premium Subsidy	----	----	($158.3)	($66.8)
Family Payments	$765.0	$997.6	$1,196.1	$1,316.3
Premium/Payroll Tax	$318.0	$585.3	$1,639.3	$1,886.5
Premium Subsidies	----	----	($1,024.6)	($1,064.0)
Personal Income Tax	$447.0	$412.3	$581.4	$493.8
Total Program Revenues	$3,638.2	$3,638.2	$3,819.0	$3,819.0
PERSONAL INCOME TAX RATE				
Personal Income Tax Rate	2.08%	1.92%	2.78%	2.36%

a Assumes that the amount of employer contributions for employee health coverage will not fall below current levels in firms that now offer insurance.

Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

EXHIBIT 28

PRIVATE EMPLOYER HEALTH SPENDING UNDER ALTERNATIVE REFORM PLANS WITH A 50 PERCENT EMPLOYER CONTRIBUTION REQUIREMENT: 1995-2004 (IN MILLIONS)



Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

C. Patient Cost Sharing

In the analyses presented above, we assume that patient cost-sharing (i.e., deductibles and copayments) is required under both the single payer and the multi-payer models. However, the single payer model was originally proposed as a program with no patient cost sharing. Eliminating cost sharing would reduce provider administrative costs by eliminating patient billing for amounts that are not reimbursed by the insurer and by eliminating the need to administer a separate program to subsidize patient cost sharing for low-income families. We estimate that eliminating patient cost sharing requirements would increase potential administrative savings under a single payer program from $359 million with patient cost sharing to $460 million without patient cost sharing ***(Exhibit 29)***.

EXHIBIT 29

SUMMARY OF CHANGES IN HEALTH SPENDING AND TAX RATES UNDER THE SINGLE PAYER PROGRAM WITH AND WITHOUT PATIENT COST SHARING

	With Patient Cost Sharing	Without Patient Cost Sharing
HEALTH SPENDING EFFECTS		
Administrative Savings[a]	$359.4 million	$460.0 million
Increased Utilization[b]	$207.6 million	$469.1 million
Net Change in Health Spending	($151.8 million)	$9.1 million
PUBLIC PROGRAM EFFECTS		
Public Program Costs	$3,689.2 million	$4,886.4 million
Employer Payroll Tax Rate	7.92%	12.67%
Family Personal Income Tax Rate	2.08%	3.33%

a Includes savings in insurer and provider administrative costs.

b Includes increased utilization for uninsured persons, underinsured persons and additional utilization induced by the elimination of patient cost sharing.

Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

However, we estimate that eliminating cost sharing would result in an additional increase in health services utilization of about $260 million. This estimate is based upon RAND Health Insurance Experiment data, which indicates that eliminating cost sharing can increase use of physician services by about 31 percent and increase use of inpatient hospital services by 10 percent.[9] These estimates are supported by a recent comparison of per-capita utilization data indicating that physician utilization in Canada, where there is no patient cost sharing requirement, is about 30 percent higher than in the United States.[10] In fact, recent studies indicate that introducing copayments in HMOs results in up to a 33 percent reduction in outpatient utilization.[11] We assumed that this increase in use would occur only among persons currently in plans that require patient cost sharing. We assume that the following groups already have coverage which in effect does not require patient cost sharing:

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[9] W.G. Manning, et al., "Health Insurance and the Demand for Medicare Care: Evidence from a Randomized Experiment," *The American Economic Review* (June 1987): 251-277.

[10] V.R. Fuchs and J.S. Hahn, "How Does Canada Do It? A Comparison of Expenditures for Physician's Services in the United States and Canada," *The New England Journal of Medicine* (27 September 1990): 884.

[11] D.C. Cherkin et.al., "The Effect of Office Visit Copayments on Utilization in a Health Maintenance Organization," Medical Care 27 (July 1989(, p. 669-679; and J.R. Hankin et.al., "The Impact of a Copayment Increase for Ambulatory Psychiatric Care," Medical Care 18 (1980) p. 807-815.

- Medicaid recipients;
- Medicare recipients who also have secondary coverage through a Medigap plan or employer retiree coverage;
- Persons in employer plans with first dollar coverage; and
- Employer plans with flexible spending accounts for direct health care payments which we treat as the equivalent of first dollar coverage for purposes of estimating utilization.

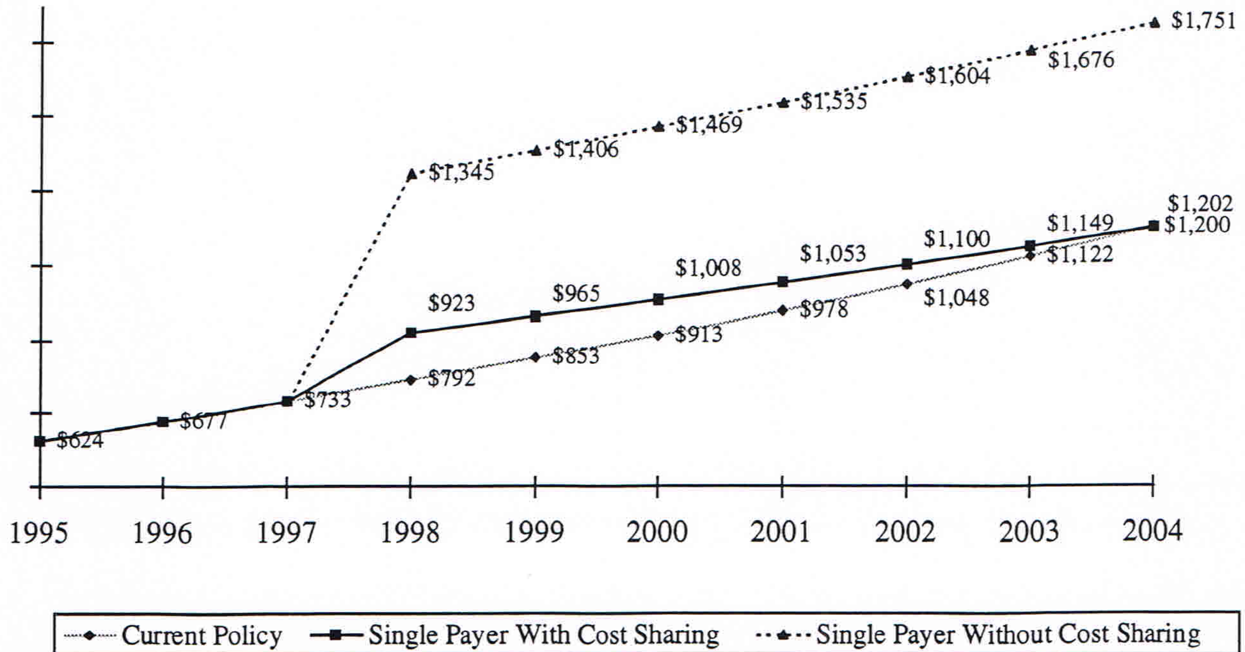
Eliminating cost sharing would result in a net increase in state wide health spending under the single payer model of $160.9 million. That is, the increase in utilization ($260 million) resulting form the elimination of patient cost sharing would be greater than the administering savings associated with the elimination of cost sharing provisions ($100 million). The single payer plan without patient cost sharing would result in a net increase in state-wide health spending of $9.1 million in 1998 compared with net savings of $151.8 million under the single payer model that includes patient cost sharing.

The total public cost of the single payer program would increase from $3.7 billion with patient cost sharing to $4.9 billion if patient cost sharing is limited. This cost increase includes the additional utilization resulting from the elimination of patient cost sharing and the cost of reimbursing amounts that would otherwise have been paid by the individual in the form of deductible and copayments. Tax rates would have to be increased to fully fund the program. The employer tax rate would increase form 7.92 percent under a program with patient cost sharing to 12.67 percent under a program without patient cost sharing. The tax rate on personal income would increase from 2.08 percent to 3.33 percent if cost sharing were eliminated.

These higher tax rates would result in higher costs for employers. Total employer costs in 1998 under the single payer model would increase from $792 million under current policy to $923 million assuming that patient cost sharing is retained ***(Exhibit 30)***. If patient cost sharing is eliminated, total employer costs in 1998 would increase to $1.3 billion due to the higher payroll tax rate under the program.

EXHIBIT 30

PRIVATE EMPLOYER HEALTH SPENDING UNDER CURRENT POLICY AND ALTERNATIVE SINGLE PAYER REFORM PLANS: 1995-2004



Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

Eliminating patient cost sharing on average would result in higher health care costs for households despite the elimination of patient cost sharing. This is because the full cost of the program, including increased utilization, is passed on to households through higher tax rates. Eliminating patient cost sharing would increase household health spending by an average of $248 per family under the single payer model as the cost of increased utilization is shifted to households in the form of higher taxes. ***Exhibit 31*** shows the average change in health spending per family by family income level under the single payer plan with and without patient cost sharing.

EXHIBIT 31

AVERAGE CHANGE IN HEALTH SPENDING PER FAMILY UNDER ALTERNATIVE REFORM PLANS IN NEW MEXICO BY INCOME IN 1998

	Number of Families (in thousands)	Average Household Spending Under Current Policy[a]	Average Change in Household Spending Under Single Payer	
			With Cost Sharing	Without Cost Sharing
Less than $10,000	132.0	$1,059	($389)	($394)
$10,000 - $14,999	60.0	$2,081	($530)	($795)
$15,000 - $19,999	45.0	$2,769	($482)	($767)
$20,000 - $29,999	96.5	$2,633	($284)	($407)
$30,000 - $39,999	60.5	$3,113	($293)	($360)
$40,000 - $49,999	49.7	$3,390	($234)	($34)
$50,000 - $74,999	95.9	$3,561	$64	$627
$75,000 - $99,999	38.1	$3,852	$940	$2,088
$100,000 or more	41.3	$4,237	$3,756	$6,588
All Families	**619.0**	**$2,684**	**$99**	**$347**

a Includes premiums and direct payments for acute care services only.

b Includes changes in premiums, out-of-pocket expenses, taxes earmarked to fund health reform, and after-tax changes in wages resulting from employer funding requirements.

Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

IX. VOLUNTARY ENROLLMENT

Both the multi-payer and the single payer plans would have achieved universal coverage by requiring all individuals to have insurance and by requiring employers to contribute to the cost of coverage. An alternative approach is to expand coverage through insurance market reforms that make insurance available to all individuals regardless of health status and to provide subsides to low-income households to help purchase coverage. This approach relies upon market reforms and subsides to encourage voluntary expansions in coverage rather than mandates upon individuals and employers to have coverage.

The New Mexico legislature has already enacted insurance market reforms that make insurance available to all small employers. All insurers operating in New Mexico are required to accept all small employer groups that apply for coverage and the insurer is prohibited from varying premiums with the health status of the group. While insurers are permitted to deny coverage to individuals due to health status, insurers are prohibited from varying premiums for the individuals that they do cover on the basis of health status. Individuals who cannot obtain coverage through a private insurer may also obtain coverage through the state's high risk pool.

These insurance rules could be strengthened by requiring insurers to accept all individuals who apply for coverage regardless of their health status. In addition, a program could be established to provide subsidies to low-income families to help them purchase individual insurance policies. The program would provide full premium subsides for all persons below poverty who are not otherwise enrolled in the Medicaid program. These subsidies would be phased out on a sliding scale with income for persons above the poverty line. We examined a premium subsidy program with the following income eligibility levels:

- **Poverty Level:** All persons below poverty would qualify for full premium subsidies.
- **To 150 Percent of Poverty:** Premium subsidies are phased-out on a sliding scale with income for persons between poverty and 150 percent of poverty.
- **To 200 Percent of Poverty:** Premium subsidies are phased-out on a sliding scale with income for persons between poverty and 200 percent of poverty.
- **To 250 Percent of Poverty:** Premium subsidies are phased-out on a sliding scale with income for persons between poverty and 250 percent of poverty.
- **To 300 Percent of Poverty:** Premium subsidies are phased-out on a sliding scale with income for persons between poverty and 300 percent of poverty.

In this analysis, we estimated the cost of these subsidies and the number of persons that would be affected under these income eligibility levels. If eligibility is limited to only persons below poverty, about 133,000 persons would enroll at a net cost to the state of $172.8 million ***(Exhibit 32)***. This includes the cost of premium subsidies and administration less offsets to existing state indigent care and mental health programs. If eligibility is extended through 300

percent of poverty, total enrollment would increase to 216,300 persons at a net public cost of $289.3 million.

EXHIBIT 32

ANALYSIS OF A VOLUNTARY PARTICIPATION PROGRAM UNDER VARIOUS SUBSIDY SCHEDULES IN NEW MEXICO IN 1998

	Subsidy Schedule: Total Premium Subsidized Below 100% of Poverty and a Sliding Scale Subsidies for Persons Above Poverty				
	To 100% of Poverty	To 150% of Poverty	To 200% of Poverty	To 250% of Poverty	To 300% of Poverty
IMPACT OF COVERAGE a/					
Number of Persons Who Enroll (thousand)	133.0	155.4	177.0	197.1	216.3
Number of Persons Remaining Uninsured (thousands)	178.4	160.3	143.6	128.1	116.9
PROGRAM COSTS					
Total Program Cost (millions)	$266.0	$301.7	$321.8	$362.9	$390.3
Administration of Subsidies	$17.7	$22.3	$27.2	$31.2	$35.8
Other State Program Offsets	($110.9)	($120.5)	($126.0)	($130.6)	($136.8)
Program Cost Net of Offsets (millions)	$172.8	$203.5	$223.0	$263.5	$289.3
PERSONAL INCOME TAX RATES					
Tax Rate Required to Fund Program	0.825%	0.972%	1.065%	1.258%	1.381%

a There are 275,000 uninsured persons in New Mexico in 1998.
Source: Lewin-VHI estimates using the New Mexico version of the Health Benefits Simulation Model (HBSM).

Even if eligibility is extended through 300 percent of poverty, about 116,900 persons would remain uninsured. Of these 116,900 who remain uninsured, about 62,000 would be persons with incomes above 300 percent of poverty who are therefore ineligible for subsidies. The remaining 54,900 persons would be individuals who would decline to participate in the program even though they are eligible for subsidies. This reflects the fact that historically, not all persons who are eligible for assistance will apply for aid. In addition, the premium for individuals who qualify for partial subsidies would often equal between 15 and 20 percent of family income, which still represents a formidable barrier to coverage.

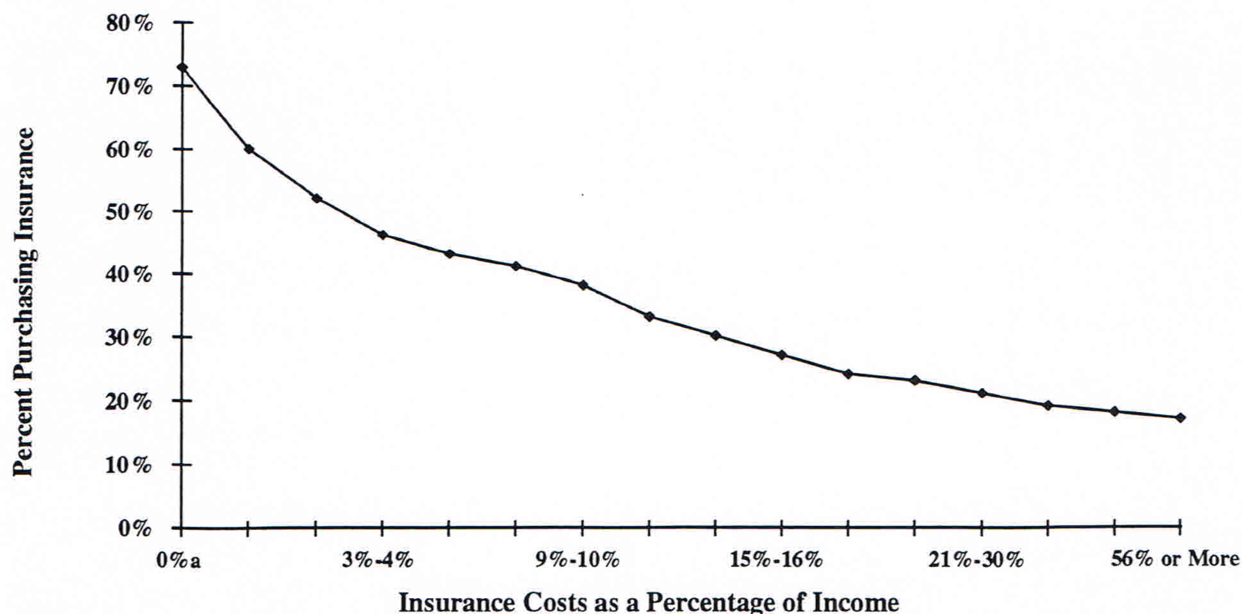
We estimated the number of persons who obtain insurance under a program of subsidized insurance coverage based upon enrollment patterns among the Medicaid population. Our analyses of major data sources indicates that roughly 25 percent of all persons who are eligible for Medicaid do not enroll. These analyses showed that, individuals in poorer health tended to be more likely to enroll than healthier individuals and that enrollment tends to drop off as economic status improves as measured by income or employment status.

The results of this enrollment analysis were used as the basis of estimating the percentage of persons who would enroll in the programs proposed in theses bills based upon the characteristics of those who become eligible. The use of health status indicators is a particularly important aspect of this analysis because it permits us to reflect in our premium and costs figures adverse selection into the program by relatively high-cost individuals.

These enrollment estimates were adjusted to reflect the fact that some individuals will receive only partial premium subsidies, thus, requiring the individual to pay a portion of the premium. This adjustment is required because the Medicaid program, which forms the basis of our enrollment analysis, does not require premium contributions for program participants. We developed an adjustment to these enrollment percentages based upon an analysis of the percentage of persons without employer insurance who purchase non-group coverage by premium costs as a percentage of income. ***Exhibit 33*** shows our estimates of how the percentage of persons electing to take coverage varies by premium costs as a percentage of income.[12]

EXHIBIT 33

ESTIMATED PERCENTAGE OF PERSONS WHO WILL TAKE SUBSIDIZED COVERAGE BY PREMIUM COST AS A PERCENTAGE OF FAMILY INCOME



a Based upon percentage of persons eligible to participate in Medicaid who enroll.

b Probabilities of enrollment are estimated initially based upon a multivariate analysis of Medicaid enrollment by age, income, health status and other demographic characteristics. These probabilities are adjusted for persons receiving partial premium subsidies by estimates of the percentage of persons purchasing non-group insurance by premium cost as a percentage of income.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

[12] The actual percentage of persons electing coverage in our analysis varies with individual health status and economic status characteristics.

X. CAVEATS

Enacting either of these reform plans would involve implementing a program that has never before been attempted on a broad scale in the United States. Consequently, there are little data on the likely outcomes of such a program that can be used to estimate its impacts. In particular, a dramatic restructuring of the health care financing system in New Mexico could substantially alter consumer, employer, and provider incentives which could have a significant impact on program costs.

Although the analysis in this paper is based upon the best data and research now available, the estimates should be considered illustrative of potential impacts rather than point estimates of actual outcomes. In fact, our analysis indicates that the ultimate impact of the plan on government health spending, employer health spending, wages and job loss is very sensitive to assumptions on employer and consumer behavioral responses under the new incentives created by reform.

Furthermore, the estimates are based on estimates of the growth in health spending which are especially sensitive to a number of factors including general economic growth and health care cost trends. Moreover, our analysis assumes that the spending controls specified in the reform plans would be effective in controlling health care cost growth in New Mexico, even though such a large scale cost control program is untested in the United States. Consequently, policy makers should recognize that any major health initiative is likely to require continued refinements in program design and financing over time