



## Toward Evidence-Based Health Care Reform Vol. 1, No. 3

### What 30% Savings? What the Lewin Study Actually Says About the Single Payer

Welcome to "Toward Evidence-Based Health Care Reform," a periodic e-memo providing facts, figures, examples and analysis of current issues in health care reform in Vermont. The memo is written by Jeanne Keller, Keller & Fuller, Inc., and sponsored by BRS, Inc., a member organization providing a range of services and support to Vermont's small businesses. For more about BRS, please visit our website: [LINK](#)

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In 2001 the Office of Vermont Health Access funded a study on the impact a single-payer system would have on health spending in Vermont.<sup>1</sup> This study, conducted by The Lewin Group, Inc. (known thereafter as "the Lewin study" or just "Lewin") is still used to back-up claims about savings from moving to a single payer system in Vermont, even if it were legally possible to do so.<sup>2</sup>

But while many still quote it, they have apparently not read the report. Lewin fans do not explain the strict managed care limitations assumed in the estimates, for example, nor do they explain where the savings come from. The "30% savings in administrative costs" hyped by single payers fans appears nowhere in the report, although Lewin is frequently cited as the source. Also, Lewin, like any study that estimates expenditures and savings, is based on a series of assumptions; unless a health care reform proposal adheres to all of the same assumptions, the proposal cannot legitimately claim even the small savings actually projected by the study.

The key findings of Lewin are in a table on p. iii of the Executive Summary. It is reprinted in its entirety below; a commentary follows.

<b>Changes in Health Spending in VT Under a Single-Payer Program 2001 (in millions)</b>		
<b>Changes in Health Services Utilization</b>		
<b>Increase in Utilization Due to Expanded Coverage</b>		<b>\$62.9</b>
Utilization Increase for Previously Uninsured	\$23.1	
Expanded Coverage for Those Already Insured	\$39.8	
<b>Changes in Administrative Costs</b>		
<b>Net Change in Admin Costs</b>		<b>(153.6)</b>
Insurer Admin costs	(106.5)	
Physician Admin Costs	(\$19.8)	
Hospital Admin Costs	(\$27.3)	
<b>Managed Care Adjustment</b>		
<b>Managed Care Adjustment</b>		<b>\$2.8</b>
<b>Prescription Drug Rebate</b>		
<b>Prescription Drug Rebate</b>		<b>(\$30.2)</b>
<b>Net Change in Health spending</b>		
<b>Net Change in Health spending</b>		<b>(\$118.1)</b>
a/ Includes all persons in the state including those with public and private coverage.		

<sup>1</sup> Sheils, John F. and Randall A. Haught. Analysis of the Costs and Impact of Universal Health Care Coverage Under a Single Payer Model for the State of Vermont: Final Report. The Lewin Group, Inc., August 28, 2001.<sup>1</sup>

<sup>2</sup> See Vol 1 No 2 of this series entitled "Why a Single Payer is Impossible in Vermont" at [www.vtreform.com](http://www.vtreform.com).

## Evidence-Based Reform Commentary

1. The biggest source of administrative “savings” (nearly 70% of the estimated administrative cost reduction) is the elimination of private insurance companies. On page 12 the study states “Overall, statewide insurer administrative costs would be reduced from \$173 million under current policy to \$67 million under the single-payer model for a net savings of about \$106.5 million in 2001.” This saving in relation to total system cost in 2001 of \$2.519 billion is a 4% cost reduction. This also means that Lewin estimates running the single payer will cost \$67 million/year. In June 2005, Rep. John Tracy told a Rutland audience the Democrats’ proposal will NOT replace private insurance, so these savings cannot be claimed for their proposal.

2. While Lewin is often quoted in a context of how high hospital and physician administrative costs are under the current system, the total savings for all hospitals is estimated at only \$27 million, or 2% of the \$1.03 billion hospital costs estimated BISHCA for the same year. Physician administrative costs would decline by around \$20 million, according to Lewin, or around 5% of costs when compared to the BISCHA expenditure budget for 2001.

Total administrative costs (hospital, insurer and physician) would decline, according to the Lewin study, by \$153.6 million. According to BISCHA, in 2001 the total system cost was \$2.519 billion. Savings of \$153.6 million out of \$2.519 billion represents a total reduction in costs of 6%.

So where does the much vaunted “30% savings” and “30% reduction in costs” estimate come from that is so often ascribed by single payer advocates to the Lewin study? It’s simply not in Lewin. As seen above, neither physician nor hospitals will see reductions greater than 5%, and even with elimination of insurance companies the total reduction in administrative cost relative to total system cost is around 6%.

The 30% figure simply does not show up anywhere in the study.

3. Lewin says savings in hospital administration would come largely from replacing billing with an annual budget. Because hospitals would be globally funded based on the projected services to be provided to patients in their service areas and would have no machinery for billing for out-of-area patients using their facility, this model must assume that patients would be required to go to the hospital whose budget includes funding for that patient. (For example, the way public schools are budgeted.) This is entirely at odds with the “free choice of provider” cited by the single payer advocates. If you retain the ability of hospitals to bill for out of area patients, you lose the administrative savings.

4. The study assumes that “provider payments are adjusted to eliminate provider windfalls for care already paid for through cost shifting.” The accompanying chart (p. 21) shows a \$50 million in new payments for the previously uninsured, offset by \$50 million reduction for prior cost shifting to other payers for those costs. However, the report does not address at all the cost impact to eliminate the cost shift from Medicare and Medicaid, which is far greater than the cost shift for the uninsured. If rates to providers for Medicaid/Medicare patients are raised to the level of private insurance payments, there would be a huge windfall to providers and extraordinary cost increase to the government payer (and taxpayers), which is entirely not addressed in this study. (See Vol 1 No 1 of this newsletter for a recent study reporting that VT has the fourth lowest cost shift for the uninsured in the nation.)

5. “The program will be reimbursed for services provided to persons who are covered under the CHAMPUS,” and “Federal Medicare program funding for Vermont residents would be transferred to the Vermont single-payer program. This includes federal funding for Part-A

and the federal share of funding for Part-B.” Unless the program envisioned by Lewin is part of a nationwide health care reform package, the program Lewin envisions is possible only by a specific Act of Congress granting this right to the state of Vermont. How likely is that?

6. Access for the currently insured would change in the Lewin model, which “would feature a primary care provider referral (i.e., gatekeeper) model... Specialist visits without a referral would be covered subject to a 50 percent copayment.” This is at odds with claims by the single payer advocates program that their plan allows entirely free choice of provider without care management. Their costs will be much higher than Lewin estimates.

According to Lewin, “the impact that these changes in the use of managed care would have on utilization, are mixed. Persons who are currently in fee-for-service plans may actually see a reduction in utilization due to the use of the primary care provider referral model. Conversely, persons enrolled in restrictive HMOs would probably tend to experience a net increase in utilization.” According to Lewin, only around 3% of Vermonters participate in HMO plans. This means that their model is predicting that 97% of Vermonters would be placed in a more restrictive plan than they now have. Again, Vermonters are not told this when being pitched the Lewin model and its “savings.”

All ambulatory (non-inpatient) care would be subject to a \$10 co-payment for all participants. The study does not waive this co-payment or discuss a sliding scale based on income; a plan that did so would experience different (i.e. higher) costs and utilization.

7. Savings of \$30.2 million over 2001 pharmacy costs are assumed by moving everyone in the state into a prescription drug program that would receive current Medicaid rebates. However, the pharmaceutical industry is not required under federal or state contracts or laws to extend their rebates to everyone in a state. (This has been the subject of lawsuits already.) Thus, these savings are not likely to accrue.

An analysis of the forecasting model used by Lewin is beyond the scope of this writer, but most likely would reveal additional surprising assumptions. What we can see, however, is that agreement with and honesty about the assumptions used and conclusions drawn is essential to having a reliable, valid and evidence-based approach to health care reform.

The legislature’s Commission on Health Care Reform will be letting contracts to consultants for more studies (in the Commission’s words) “in support of the goal of providing full and universal access to health care in Vermont.” An economic impact study will “contrast the effects of the current health care system to the effects of a system providing universal access to health care on Vermont’s economy, including effects on businesses, employment, economic growth, economic competitiveness, providers of health care, health insurers, and Vermont residents.” The financing study will “compare alternative mechanisms to fund the state’s health care system, including but not limited to income tax, payroll tax, consumption tax, more limited taxes, risk pools, and tax credits for the purchase of health insurance. The comparison shall consider relative effectiveness in achieving the goal of universal access.” Another consultant will do research yet undefined.

**We hope that when choosing consultants, outlining their study plans and evaluating their final reports, the Legislative Commission will carefully review and disclose to the public all underlying assumptions and apply study results correctly, in the spirit of Evidence-Based Health Care Reform.**