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Financing Health Care Reform

A Plan to Ensure the Cost of Reform Is Budget-Neutral

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Introduction

Financing issues are among the most difficult problems in health care. Because of the deteriorating federal budget, health care reform needs to be budget-neutral over the course of the next decade. After that interval, health reform needs to reduce projected deficits, or the budgetary situation will become untenable. To make this happen, health care reform needs to insure that all Americans have health insurance coverage.

Increasing coverage and saving money requires a complex combination of short- and long-run policies. In this paper, we lay out a set of policies that focus particularly on how the medical care system can be modernized so that it costs less and delivers more in terms of quality care. Alongside these policy proposals, we present options for guaranteeing the budget neutrality of health care reform through a series of "failsafe" policy proposals that could be implemented as needed.

A framework for health care financing

Health care reform is still a work in progress, but some of the outlines are clear. The major cost of reform is the money necessary to make health insurance affordable for all Americans—either by offering tax credits for private coverage or by expanding public programs. The exact cost of these initiatives depends on the benefits that people are guaranteed and the financial help they get in paying for them. Such costs will likely be between $1 trillion and $1.5 trillion over 10 years. In this paper, we consider financing $1.2 trillion in spending.[1]

Health care reform can be responsibly financed through a combination of reduced spending in current public programs—Medicare, Medicaid and the State Children's Health Insurance Program—and new revenues. We consider the financing in three roughly equal ways. The first source is from traditional savings in public programs by reducing or eliminating spending generally recognized as excessive relative to costs. The second source is additional revenues from within or outside of the health system. Finally, there are savings that come from modernizing the delivery of health care—payment and other reforms to promote more efficient delivery of medical services. Let's consider each in turn.

Traditional savings in public programs

Traditional cost savings in health care come from reducing prices paid to health care providers such as physicians, hospitals, and clinics for providing medical services. In many cases, these reforms are designed to correct the misallocation of resources that flow from having payments that are too generous or not generous enough. Such savings are a useful complement to long-term modernization of the health system because they reduce rewards to health care providers when they overprescribe care, encouraging them to seek the reward of better-quality care through the greater efficiencies that health information technology infrastructure reforms, comparative effective research, and payment innovations will provide.[2]

President Obama has put forward more than $600 billion of such savings. The specific policies include:

- Incorporating expected productivity improvements into payment updates for hospitals
- Competitive bidding for the Medicare Advantage program offered by private insurers

- Reallocating a portion of Medicare and Medicaid disproportionate share payments—payments to hospitals that care for uninsured people—as the share of people without insurance coverage falls
- Reducing pharmaceutical spending in Medicare and Medicaid
- Tying home health payments more closely to costs
- Reallocating already-legislated Medicare improvement funds

We presume that reform agrees to $400 billion of these savings.

Additional revenue

New revenues are a second component of reform. There are many possible ways to raise $400 billion to support health care reform, some coming from policies directly related to health care, others from more general tax policy.

A first source of revenues comes from a "pay-or-play" requirement. A company (perhaps above a certain size) that does not provide insurance contributes a specified dollar amount or percentage of payroll toward coverage in an insurance exchange, which are insurance pools are set up to bring the price and quality of large company insurance plans to individuals and small companies. Typical health care policies proposed along these lines generally raise about $120 billion to $350 billion over 10 years.

A second source of revenues is limiting tax preferences for medical spending. The largest issue here is the preferential tax treatment of employer-provided health insurance. The tax preference issue might be addressed in one of two ways: either limiting the deductibility of health insurance for employers, or limiting the amount that employees can exclude from income. Congress's Joint Tax Committee estimates that limiting the tax exclusion to the cost of the federal government's employees' plan would raise between $130 billion and $420 billion over a decade, depending on whether the exclusion is limited to higher-income individuals or extends to the whole population. Limiting the tax deductibility of health insurance for companies would likely raise a similar amount.

Congress might also consider eliminating the exclusion for health expenditures made through flexible spending accounts and health reimbursement accounts, or eliminate the itemized deduction for medical spending over 7.5 percent of income. These polices raise nearly $250 billion over a decade.

A third option is sin taxes. Taxes on cigarettes, alcohol, and sugar-sweetened beverages reduce consumption of these products, thus contributing to the overall health of the American people, and raise significant revenue—an estimated $200 billion over the next decade.

There are a number of non-health options as well, though because of the vast potential range we do not present specifics. But we note that it is straightforward to design policies that would yield $400 billion or more in additional revenue over the next decade.

Health care modernization

Long-term cost saving requires more than simply reducing payments for certain services. It requires restructuring the health care system in far more fundamental ways. The idea underlying health care modernization is that the delivery of health care is inefficient, and this inefficiency drives up spending and lowers the quality of care. That's why it is possible to simultaneously lower the cost of medical care and improve its quality.

The reforms we propose work on the idea of shared savings. As medical costs fall, savings can be shared with providers and still be used to reduce federal budget deficits. This is true because even though costs are high, profit margins are low. Consider a specific example. Suppose that as a result of administrative efficiencies, operational changes, and better preventive care, hospital costs fall by 15 percent. Imagine that the federal government responds to that 15 percent savings by raising hospital payments by 4 percent. The government will still save 11 percent, reducing the deficit by that amount, and hospital profits will rise by 4 percent.

Since the typical hospital has a profit margin of only 4 percent, this represents a doubling of hospital profits. By using the principles of shared savings, reform can ensure that the benefits of reform are shared by everyone. A number of specific changes would contribute to modernizing health care, which are discussed in more detail in a separate paper.[3] The broad areas include:

- **Putting in place the infrastructure for health system transformation.** This must include health information technology and comparative effectiveness research. Health information technology, implemented thoughtfully,[4] can reduce administrative spending and support health care providers with the data they need to assure appropriate treatment and effective management of their patient populations—especially patients with chronic illness. Health IT can also provide the data needed to assure accountability for quality care under shared-savings approaches to payment reforms such as bundled-care payment systems, which pay for entire episodes of care, or accountable-care organizations, which reward providers for efficiently coordinating care. Federal funding for comparative effectiveness research also is a component of this strategy, to inform both providers and patients on the most appropriate treatment strategies to meet their needs. Information technology, combined with comparative effectiveness research, would also allow the Centers for Medicare and Medicaid Services, or CMS, to measure and disseminate information on the cost and quality of individual providers and provider groups.

- **Empowering health professionals and consumers to make appropriate care decisions.** At the consumer end, empowerment entails the provision of price and quality information, adjusting cost sharing to encourage use of valuable services, and using health information technology to engage patients in caring for their own health. Health professionals can be empowered by loosening restrictions on the scope of practice for nurses, physician assistants, and other providers, promoting efficiency by allowing the full range of providers to practice their full range of skills.

- **Changing the payment system for health care to reward value over volume.** Health care modernization requires a move away from rewarding increased volume of high-cost medical procedures toward rewards for prevention and efficient management of patient care, especially patients with high-cost chronic conditions. Medicare has the leverage to lead this modernization because its payment innovations have been and likely will be adopted by the rest of the marketplace. Medicare could create opportunities for cost savings and quality improvements by allowing providers to focus on quality care that achieves savings while improving quality to earn a share of those savings. Experts see particular promise in payment innovations that reward primary care and chronic care management practices that "bundle" services typically paid for separately into a single payment, and encourage collaboration and coordination among health care providers who currently practice, as most do, in small groups.

Innovative arrangements in care management could be initiated by physicians, hospitals, insurers, pharmaceutical companies, and even companies outside the health care field. Medicare can jump-start the development and adoption of system-wide reform through extensive demonstrations, rigorous evaluation, transparency and regular public reporting, and authority to broadly implement payment methods demonstrated to promote savings without seeking additional congressional action.[5]

There is a range of estimates of possible savings from these proposals. The experience of other industries provides one guide. Information technology and the payment and organizational reforms that can accompany it led to enormous productivity improvements in most industries in the 1990s. Productivity growth rose from just over 1 percent annually in the 1970s and 1980s to 2.5 percent annually since 1995. Information technology and the other changes it enabled are the widely accepted source of this. Such productivity increases have been matched by health care organizations such as the Veterans Administration and group health care organizations such as Kaiser Permanente in California and Geisinger Health System in Pennsylvania.

Extrapolating from this, we estimate that these proposals will yield cost savings of 1.5 percentage points annually, after an initial phase-in period.[6] Leaders of the medical care industry endorsed the same conclusion in their letter to President Obama in May 2009. Cost-growth reductions of 1.5 percentage points annually would result in federal cost sav-

ings and revenue increases of $584 billion over 10 years.

Other studies have tried to parcel out how such savings would be realized, based on analysis by the Congressional Budget Office and other agencies. Table 1 shows more information.

TABLE 1

Impact of health care modernization on the Federal Budget, 2010–2019

Category	$ billion
Administrative savings associated with technology and payment reform	$196
Savings from pooling small firms into larger groups	$64
Impact of fewer and less expensive acute care episodes	$299
TOTAL	**$559**

The first set of savings comes from administrative efficiencies associated with information technology and associated organizational and payment reforms. These savings build on estimates of the savings from information technology that come from Congressional Budget Office estimates. But they go beyond them to consider the impact of simplified documentation and reductions in wasteful interactions on professionals' time. Experience indicates the likelihood of increasing nursing productivity by perhaps 30 percent, and improving the productivity of physicians as well.

The second savings are lower administrative costs for small businesses that buy insurance as part of insurance exchanges. The lower premiums that result will increase revenue to the federal government because they lower tax-preferred spending on premiums.

The third, and largest, savings results from fewer and less expensive acute episodes of care. Increased use of preventive care, management of chronic illness, reduction in medical errors, and other improvements in care will result in fewer acute episodes, and payment and organizational changes will reduce the cost associated with each episode.

The net impact on the federal budget from slowing costs in this way is an improvement of more than $550 billion. Almost three-quarters of this is a result of reduced Medicare and Medicaid costs. A smaller share comes from less rapid increases in tax-preferred private premiums as the premiums that companies pay for insurance fall and more compensation is paid out as taxable.[7]

Modernization savings are vitally important, but also somewhat speculative. Recognizing the uncertainty that health care system reform will save the necessary amounts in the time

Failsafe policies

required, we also identify spending reductions and constraints that could be triggered to assure adequate financing for health reform and an overall slowdown in the nation's health expenditure growth—if experience falls short of expectations. These "failsafe" proposals are clearly intended as a last resort and acceptable only in the context of health reform directed at affordable health care for everyone.

These failsafe proposals could be designed to achieve one or both of two goals:

- Guaranteeing adequate financing for new and existing federally financed health coverage
- Guaranteeing a specific growth rate in the nation's health care spending, for example, by guaranteeing that cost increases will decline by 1.5 percentage points annually due to productivity improvements

From a purely fiscal point of view, the first of these is more important. But the second is more important for the economy as a whole. All the policies affect federal revenues; we indicate how much.

A central issue is determining how the failsafe should be triggered, and who should decide on the specific steps taken. A menu of policy measures can be specified in advance. But to automatically apply these measures without assessing where the financing problems are or which actions would best address them would be problematic. Having flexibility over which options to pursue would allow targeted solutions to be pursued and would enhance effectiveness.

We therefore recommend both a set of possible policy actions and the establishment of a commission with the authority to select among them—subject to being overturned by Congress. Recent proposals have called for the Medicare Payment Advisory Commission—an independent congressional agency that advises Congress on Medicare—to become an independent, expert decision-making body within the Executive Branch holding such authority, though this is not the only possible organization.

For a failsafe trigger to work, medical spending would need to be monitored, presumably on at least an annual basis, and at a determined point, any projected "imbalance"

or "excess spending" would trigger the failsafe for the following year. For our budget calculations, we consider what policies might be implemented in 2015, based on spending results to that point.

Limits on Medicare payments

The Medicare payment system operates on annual update formulas for particular health care providers. Updated payments can be readily dialed up or down. Indeed, they have been in the past. President Obama included limits on hospital updates to reflect productivity gains in his list of savings dedicated to finance health care reform. We also would extend these limits to non-hospital health care providers.

Estimates suggest that update limits on Medicare payments outside the hospital industry (for example, in skilled nursing facilities and home health organizations) to account for assumed productivity would save about $56 billion over five years. We assume President Obama's proposal is enacted and put the others on the failsafe list, though other combinations are clearly possible.

The Medicare Payment Advisory Commission, or MedPAC, estimates that payments to teaching hospitals are above the additional costs that teaching imposes. As part of a comprehensive strategy to encourage more primary care relative to specialty care, Medicare could realign payment for graduate school medical education to better reflect costs and to enhance support for primary care training. This could save $38 billion over 10 years.

Finally, payments in high-cost areas could be reduced to encourage more appropriate utilization of health care products and services. This would save $39 billion over five years. These measures to further reduce the rewards for health care providers to order up too many costly services could be accompanied by measures to more rapidly implement payment reforms in Medicare, a public plan or in private health insurance plans, to promote system modernization.

Lowering traditional Medicare payment rates encourages health care providers to reduce their costs and to participate in alternative payment arrangements that reward greater efficiency and, by promoting efficiency, can lower spending throughout the system. But too great a reliance on this mechanism has the potential to increase a gap that already exists between Medicare rates and the rates private insurers pay providers. It might potentially shift costs to private payers, or result in access problems for Medicare beneficiaries or other individuals. The failsafe therefore includes additional steps.

Limits on other public subsidies

A second part of the failsafe focuses on new subsidies for health coverage and the existing tax exclusion for employer-provided health insurance. The simplest way to constrain subsidy costs would be to constrain annual rates of growth —independent of premium or health care cost increases. A health reform proposal by Sen. Ron Wyden (D-OR) specifies that insurance subsidies increased at only the rate of overall inflation. Table 2 shows that allowing the growth of potential new subsidies to increase by only the growth rate of overall inflation in the latter five years would save $102 billion.

Similarly, limits can be established on premium subsidies through the tax exclusion. We assume that limiting the tax preference for employer-provided health insurance will be one component of financing. One way to save money, if need be, is to tighten the preference further. For instance, the corporate exclusion could be applied to additional costs, or an individual exclusion could be applied to lower levels of income. This would raise about $100 billion in revenues over five years.

TABLE 2

Failsafe savings options, 2015–2019

Category	$ billion
Policies to address Medicare costs	
Limit growth of Medicare payments to account for productivity	$56
Align teaching hospital payments with costs	$38
Reduce payment rates in high cost areas	$39
Policies to address subsidy costs	
Make subsidies contingent on savings	$102
Additional tax preference restrictions	$109
Updating cost sharing and eliminating Medigap spillover	$48
Pay Medicare rates in public insurance plan	$86
Policies to address private insurance premiums	
Pay Medicare rates in all private plans	$109
TOTAL	**$588**

In addition, we add changes in cost sharing for Medicare beneficiaries. We consider an option in which cost sharing for acute care services is harmonized between Medicare Parts A and B (inpatient and outpatient care, respectively) and in which coverage is expanded to catastrophic circumstances. This provides more catastrophic protection but involves a modest increase in overall cost sharing.

As part of including catastrophic coverage, so-called Medigap plans, which pay for out-of-pocket costs that Medicare does not cover, would also be taxed to account for the cost

increase they lead to in the traditional Medicare program. This package of reforms would save $48 billion over five years.

Lowering private premiums by empowering a public plan to pay Medicare rates

Establishing a publicly run health insurance plan can promote effective competition among insurers. Based on the current debate, political agreement on enacting such a plan may include restrictions on its operations that will undermine its cost-savings potential. Under the failsafe, the public plan would be allowed to pay at Medicare rates. Providers would have to accept these rates or risk reductions in their Medicare rates.

Paying Medicare rates would undoubtedly make the public plan the "lowest-cost plan"—the plan to which subsidies will likely be tied. It therefore immediately lowers federal subsidy costs. In addition, it would make it both easier and necessary for private plans to lower their rates in order to compete. We estimate that subsidy costs could fall by 10 percent. This change would also lower the cost to individuals and small firms buying insurance through an exchange.

Lowering private premiums by extending Medicare rates to private insurers

The extension of Medicare rates to a public plan for the non-elderly might be coupled with a proposal to allow private health insurance companies access to Medicare rates,[8] again requiring health care providers to accept those rates. In many markets, the concentration of health care providers makes it difficult for insurers to limit rates. This authority would simply override the market power of health care providers to set prices for their services. Assuming that private premiums fall by 10 percent, this would raise an additional $109 in revenue through less tax-sheltered income.

Implementing the failsafe

In the five-year window between 2015 and 2019, the overall amount of failsafe savings is $600 billion. This is above the estimate of savings from health care modernization and suggests that we can be sure about this dollar amount of savings—even if not the exact mechanism. Automatic implementation of the policies listed here would therefore guarantee budget neutrality and full financing of a health reform plan.

These policies, however, are blunt instruments. Far preferable would be the ability to tailor policy interventions to actual spending problems—Medicare cuts if Medicare

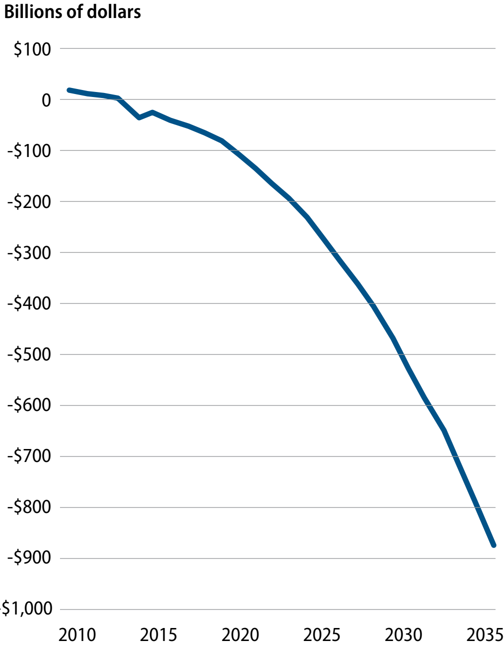
spending proves too high; private spending constraints if private premiums continue to grow. The advantage of a commission is its ability to tailor policy actions to problems actually experienced.

In combination, the traditional savings mechanisms, new revenues, and modernization measures (backed up by failsafe programs), generate about $1.5 trillion over 10 years.

Conclusion

Thus, a $1.2 trillion investment in health care reform is feasible in the 10-year time period.

If health care reform savings come from productivity improvements, then after a decade slower cost growth will contribute to deficit reduction. Figure 1 shows the consequences of health care reform and productivity improvements on the federal budget over the next quarter-century. For the first decade, reform as a whole would be roughly budget-neutral as savings are used to pay for new coverage.



Over time, the savings increase in magnitude, while the costs increase less rapidly. Annual savings are $368 billion by 2025, or 1.4 percent of U.S gross domestic product. By 2035, annual savings are $1.2 trillion, or 3 percent of GDP. Thus, there are long-term budget savings from health care reform.

About the authors

Endnotes

2 Paul B. Ginsburg, "Efficiency and Quality" (Washington: Center for American Progress Action Fund, June 2009).

3 Melinda Beeuwkes Buntin and David Cutler, "The $2 Trillion Solution" (Washington: Center for American Progress Action Fund, June 2009).

4 Todd Park and Peter Basch, "A Historic Opportunity: Wedding Health Information Technology to Care Delivery Innovation and Provider Payment Reform," (Washington: Center for American Progress, May 2009), available at http://www.americanprogress.org/issues/2009/05/health_it.html.

5 Ellen-Marie Whelan and Judy Feder, "Payment Reform to Improve Health Care: Ways to Move Foward," (Washington: Center for American Progress, June 2009).

6 David M. Cutler, "Health Care Modernization Will Reduce the Deficit" (Washington: Center for American Progress Action Fund, May 2009).

7 These savings are net of the tax exclusion changes presented above.

8 Medicare rates might need to be changed a bit, for example to make them more accurate for children.

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1 Throughout the paper, we refer to the 10-year period from 2010 through 2019. Most cost estimates are from the Congressional Budget Office.

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