FOCUS on Health Reform

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EXPLAINING HEALTH CARE REFORM: How Might a Reform Plan Be Financed?

Introduction

One of the key challenges in enacting a health care reform plan is how to finance it among government, employers, and individuals. Of particular concern to policymakers is what effect a health reform plan would have on government spending and the federal budget. President Obama and Congressional leaders have said that any health reform plan should not add to the budget deficit over a 10-year period. This means that the added federal budgetary spending resulting from reform would be fully offset by new revenues or savings in existing government obligations (such as Medicare and Medicaid). Some have suggested that beyond this 10-year window, reform could actually help to reduce the projected budget deficit over time, with savings and new revenues exceeding the costs associated with reform.

This brief explains the likely sources of added costs under reform, the types of financing measures being considered, and some of the key questions likely to be addressed by how a plan is financed.

Cost of Reform

By far the largest component of new budgetary spending under a comprehensive, universal coverage plan is subsidies to the uninsured (65% of whom are below 200% of the poverty level) to enable them to afford coverage. These subsidies could be provided through coverage in expanded public programs like Medicaid and the Children's Health Insurance Program (CHIP), direct financial assistance towards the purchase of private or public insurance, or tax credits to offset the cost of coverage. Even though these subsidies add costs to the federal budget, they reduce the cost of health care for families, in effect transferring money from the government to individuals.

In addition to the cost for subsidies to make coverage more affordable, there are other potential (though likely smaller) government costs that are likely to be part of a broad health reform initiative, including: investments in infrastructure (e.g., IT or comparative effectiveness research), administrative expenses, and other forms of subsidies (e.g., assistance for small businesses).

A recent letter from the Congressional Budget Office to the chair of the Senate Committee on the Budget suggested that subsidies under health reform could cost "on the order of $100 billon" per year in current dollars, depending on the specifics of the plan. The 10-year cost would depend on what level of subsidy assistance is provided, when a new program would begin and how fast expenses grow over time. The 10-year cost of reform is likely to be about $1 trillion or more.

Financing Approaches

Financing these added government costs means offsetting them in some way so they do not increase the federal deficit, either through savings in other government programs or additional revenues. Financing approaches generally fall into three main categories:

1. **Specific changes to produce savings in existing public programs like Medicare and Medicaid.** If changes result in savings over the next 10 years relative to what these programs are projected to cost (generally referred to as the "baseline"), then the savings could be used to offset the added cost of health reform. For example, in his budget request and then in a subsequent proposal, President Obama called for the creation of a health reform reserve fund, which included $622 billion in savings in Medicare and Medicaid over a 10-year period, in addition to $326 billion in additional revenues. Savings proposals include: $177 billion from reducing payments to private Medicare Advantage plans by moving to a system of competitive bidding; $110 billion from incorporating increases in economy-wide productivity into Medicare payments to providers; $106 billion from reducing subsidies to hospitals for treating the uninsured as coverage expands; $75 billion from lower than expected prices for drugs under Medicare; $25 billion from reducing readmissions to hospitals under Medicare; and $20 billion from higher Medicaid rebates paid by drug manufacturers.

The savings from these changes would primarily accrue to the federal government, though there are also cases where changes in public programs could serve as an example for the private sector and leverage additional savings. For example, the recently enacted stimulus bill included incentives and penalties under Medicare and Medicaid to encourage providers to adopt health information technologies, which could yield savings not only for public programs but for private sector payers as well.

2. **New revenues from sources within the health care system.** A reform plan could include provisions related to restructuring the health system that would also raise federal revenues and be used to offset new costs. For example, a pay-or-play requirement on employers—requiring businesses to either provide coverage to their workers or pay a fee to help pay for government-provided subsidies—would both bolster employer-based coverage and increase revenue.

   Another example would be to change the tax treatment of employer-sponsored health insurance, an idea that Senate Finance Chair Max Baucus has suggested be explored as an option on the table. Right now, employer contributions for health insurance are not taxable as income for employees, unlike their wages. This in effect means that the government is subsidizing a portion of the cost of health insurance, since the benefits are provided tax-free. This tax exemption costs the federal government an estimated $245 billion per year.[1] Changes to the tax treatment of health insurance would both raise revenues for reform and change incentives in the health system. For example, capping the exemption at the level of the standard option plan under the Federal Employee Health Benefit Program (FEHBP) is estimated to generate $418.5 billion in revenue over a 10-year period, while capping the exemption at FEHBP for higher income employees only is estimated to generate $161.9 billion.[2] In addition, without an open-ended tax subsidy, employers and employees might move towards less generous plans (e.g., with higher cost sharing) that would likely result in workers and their dependents using less health care but also paying more out of pocket for their care.

   There are a variety of other ways the tax system subsidizes health care expenses, which could be modified to generate additional revenue. For example, a recent options document from the Senate Finance Committee included a proposal to limit or eliminate the ability of workers to put aside money on a tax-free basis to pay for health care or insurance through flexible spending accounts (FSAs).

3. **New revenues from sources outside of the health care system.** From the perspective of federal budget accounting, it is irrelevant whether new revenues are specifically related to health care or not. For example, the Obama Administration proposed to cap the amount of itemized deductions for higher income people and dedicate the estimated $267 billion in revenues over 10 years to the health care reform reserve fund. The House Tri-Committee proposal includes a graduated tax surcharge of 1-5.4% on income in excess of $280,000 for single taxpayers and $350,000 for families, producing $540 billion in revenue over 10 years. Others have suggested that a value-added tax could be used to finance the federal cost of health reform.[3] There are also proposals for taxes related to "lifestyle," which while technically outside of the current health care financing system could encourage healthier behaviors. For example, the Senate Finance Committee options paper included a uniform tax on beverages based on alcohol content and a new excise tax on sugar-sweetened drinks.

KEY QUESTIONS

1. How sustainable is the financing over time?
Policymakers have suggested that health care reform would have to be budget neutral—that is, not add to the federal deficit over a 10-year period. But, an important question is how new costs would be balanced against new revenues and savings in existing government programs over time, beyond the initial 10-year period. Addressing this question involves a tremendous amount of uncertainty, since it is difficult to forecast health and economic indicators over an extended period of time, let alone the effects of reform. Yet, there are number of factors that would influence the likelihood of fiscal sustainability over the long term, including:

- **The growth of revenue and savings sources relative to costs.** Historically, health care costs and insurance premiums have grown an average of about 2.5 percentage points faster than the economy as a whole. Unless that growth is diminished through health system changes, or revenue sources are identified that grow equally as fast, a long-term fiscal imbalance could result. Similarly, one-time savings in health care costs that do not grow over time may not be sufficient to keep pace with cost increases.
- **How government subsidies are structured.** Many design decisions in a reform plan could affect its finances, some quite substantially.

KEY QUESTIONS (continued)

For example, the Healthy Americans Act sponsored by Senators Ron Wyden and Bob Bennett ties the subsidies for low and modest income people to a benefits package whose value grows with per capita growth in the economy. This would help to control the growth in subsidy costs. But, to the extent that health care costs grow faster than the economy—which has historically been the case—tying the value of coverage to economic growth would erode the protection available to people receiving subsidies over time.

- **The timing of savings.** Policymakers have discussed a variety of steps they hope will make the delivery of health care more efficient. For example, many analysts point to the fact that the amount of health care that people use varies substantially from one area of the country to another, without measurable differences in quality or outcomes. There have been a number of ideas proposed to narrow these cost disparities and improve value in the health system, including greater adoption of information technologies, research to identify which technologies and treatments are effective and which are not, better management and prevention of chronic diseases, and payment systems that reward providers for improved quality and efficiency. Changes to the health care delivery system may produce savings in government health insurance programs, but it could take many years for those savings to be realized. The Obama Administration has suggested that these long-term—and uncertain—savings should not be assumed in the financing of health reform over the next 10 years, but could lead to an improved federal fiscal picture over an extended period of time.

2. Is the financing progressive or regressive?

One measure of the burden of a tax policy is how progressive it is—that is, do people with higher incomes pay a larger share of their income in taxes. In many respects, the current health care system is regressive. People with private insurance generally have to pay the same insurance premium regardless of income, which represents a much higher percentage of income for lower-income people than for those with higher incomes. These payments are therefore regressive. The current tax exemption for employer-sponsored coverage is also regressive, providing greater benefits for those with more income and in higher tax brackets. An important policy question is whether new financing sources are more or less progressive than current ones.

3. What is the balance of financing among individuals, employers, and government?

The reform plans currently under consideration by Congressional committees are generally referred to as "shared responsibility" approaches. This means that the financing could come from a mix of sources, including savings in government programs and new revenues, premium and out-of-pocket payments by individuals, and premiums or fees paid by employers. States could also see increases or decreases in spending from reform (e.g., related to an expansion in Medicaid, or through changes in safety net programs as a result of more people being covered by health insurance). How these different sources are balanced will likely influence whether various groups perceive that they will be better or worse off.

Assessing how different people and sectors could be affected by reform requires a broader view of financing than simply looking at the federal budgetary balance sheet. Some individuals could see decreases in payments (e.g., as a result of subsidies for health insurance or out-of-pocket costs) or increases (e.g., if their employer-sponsored benefits are decreased or eliminated). Similarly, employer payments for health insurance could go up or down, apart from any fees they might be required to pay to the federal government. And, to extent that measures to improve the efficiency of the health system are effective, many individuals and employer could see lower than expected costs over time.

Conclusion

People are likely to judge a health reform plan based on what it means for them personally and their families. With the exception of financing, many elements of reform would seem to provide benefits to people—a guarantee that insurance is accessible regardless of a pre-existing health condition and subsidies to make coverage more affordable. However, it is in the financing of reform that many of the costs come into play, whether it's additional taxes that some people or employers must pay, or savings in public health insurance programs that affect beneficiaries, providers of health care or insurers. Ultimately, any assessment of reform will depend on a full picture of who benefits and who loses, driven in large part by how it is financed.

Resources

Budget Resolutions – Senate: http://budget.senate.gov/democratic/documents/2009/Conf.%20Rpt_S.%20Con.%20Res.%2013.pdf; House: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_reports&docid=f:hr060.pdf

Congressional Budget Office – Letter to the Honorable Kent Conrad, Chairman, Senate Committee on Budget, June 16, 2009: http://www.cbo.gov/ftpdocs/103xx/doc10311/06-16-HealthReformAndFederalBudget.pdf

The Dartmouth Atlas of Health Care: http://www.dartmouthatlas.org/

Jon Gruber for the Kaiser Family Foundation – The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond: http://www.kff.org/insurance/upload/7566.pdf

House Ways and Means Committee – How the Health Care Surcharge Works: http://waysandmeans.house.gov/media/pdf/111/htsw.pdf

KaiserEdu Tutorial – A Primer on Tax Subsidies for Health Care: http://kaiseredu.org/tutorials_index.asp

Kaiser Commission on Medicaid and the Uninsured – Approaches to Covering the Uninsured: A Guide: http://www.kff.org/uninsured/upload/7795.pdf

Kaiser Family Foundation – Comparing Projected Growth in Health Care Expenditures and the Economy: http://www.kff.org/insurance/snapshot/chcm050206oth2.cfm

Kaiser Family Foundation – Pulling It Together, From Drew Altman: What Will Health Reform Do for Me? http://www.kff.org/pullingittogether/022609_altman.cfm

Kaiser Family Foundation – Tax Subsidies for Health Insurance: http://www.kff.org/insurance/upload/7779.pdf

Obama Budget Proposal, A New Era of Responsibility: http://www.whitehouse.gov/omb/assets/fy2010_new_era/A_New_Era_of_Responsibility2.pdf

Office of Management and Budget – The Health Care Reserve Fund: A Historic Commitment to Reform: http://www.whitehouse.gov/omb/blog/09/05/09/TheHealthCareReserveFundAHistoricCommitmenttoReform/

Office of the White House Paying for Health Care Reform: http://www.whitehouse.gov/MedicareFactSheetFinal/

Senate Finance Committee – Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans: http://www.finance.senate.gov/sitepages/leg/LEG%202009/051109%20Health%20Care%20Description%20of%20Policy%20Options.pdf

ENDNOTES

1 Kleinbard, E. "Summary of Testimony for Senate Finance Committee Hearing: 'Health Benefits in the Tax Code: The Right Incentives'" July 31, 2008, available at http://www.jct.gov/publications.html?func=startdown&id=1194.

2 Joint Committee on Taxation, Letter to Senate Finance Committee Chair Max Baucus and Ranking Member Charles Grassley, June 2, 2009, available at http://www.newamerica.net/blog/files/Exclusion%20revenue%20estimates.pdf

3 Emanuel E. J., & Fuchs, V. R. "A Comprehensive Cure: Universal Health Care Vouchers," Brookings Institution, Washington DC, 2009, available at http://www.brookings.edu/~/media/Files/rc/papers/2007/07useconomics_emanuel/200707emanuel_fuchs.pdf; Lambrew, J. M., Podesta, J. D., & Shaw, T. L., Change in Challenging Times: A Plan For Extending And Improving Health Coverage Health Affairs Web Exclusive, (2005): w5-119 w5-132.

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