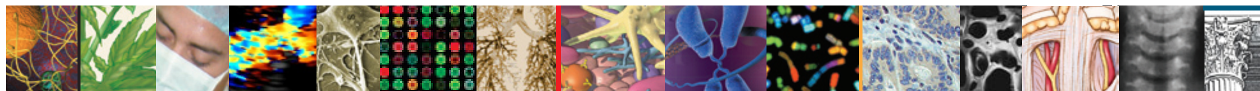

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Perspective

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Picking the Right Poison — Options for Funding Health Care Reform

Jonathan Oberlander, Ph.D.

The Clinton administration's ill-fated 1993 Health Security Act has at last become a model for health care reform — though not in the way its architects envisioned. The Obama administration and congressional reformers are using the Clinton plan as a blueprint for how not to pass health care legislation. In 2009, reformers are pursuing a strategy that, in key respects, does exactly the opposite of what the Clinton administration tried in 1993 and 1994.

Delay helped to doom the Clinton plan's political prospects, so the Obama administration is moving quickly to push reform forward. The Clinton administration developed a remarkably detailed, 1342-page plan that provided opponents with an inviting target. In contrast, the Obama administration has not released a plan, instead offering up a list of eight principles — its plan, in other words, is not to have a plan. And whereas the Clinton administration handed down its plan to a Congress that it mistakenly assumed would follow its lead, the Obama administration is giving Congress primary responsibility for drafting legislation.

Congress, too, is applying lessons from the 1990s debacle. Key Democratic lawmakers are substantially more unified around health care reform than their predecessors were 16 years ago. They have decided that this year offers the best chance for passing comprehensive reform and are therefore moving quickly. They are also striving to build support among stakeholder groups that helped to kill the Clinton plan, including business and the insurance industry.

Thus far, the strategy of using the Clinton plan as a "reverse playbook" to guide health care reform in 2009 appears to be paying off. However, better strategy can carry reform only so far. The chances of legislative victory ultimately depend on solving a tricky puzzle: how to pay for health care reform.

The political arithmetic is daunting. The plan outlined by Barack Obama during his presidential campaign would offer universal access to health insurance by creating new private and public insurance options for the uninsured, along with subsidies for lower-income persons to purchase coverage. (A proposal outlined by Senator Max Baucus [D-MT] takes a similar approach.)

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The costs of such a plan are somewhere in the neighborhood of $1 trillion to $2 trillion over 10 years.

To be sure, the $100 billion to $200 billion a year in new spending would represent only a modest increase for a health care system that already spends over $2 trillion annually. But such economic perspective does not make the political task any easier. Even if universal coverage saves money in the long run, congressional pay-as-you-go budget rules and the administration's commitment to health reform that pays for itself mean that reformers must find money to finance a substantial insurance expansion. The $1.7 trillion federal deficit also looms over the health care debate, with fiscally conservative Democrats in Congress demanding that reform be fully funded in exchange for their support.

Where, then, can reformers get the money? It is tempting for Congress to count on savings from health information technology, prevention, pay-for-performance systems, a primary care "medical home," and other measures that aim to improve medical care delivery and health outcomes. Unfortunately, there is not solid evidence that these measures will save much money.[1] The Congressional Budget Office (CBO), the independent scorekeeper for legislative costs, will consequently not score much in the way of savings from these policies.[2]

In 1993, the Clinton administration faced an analogous dilemma when the CBO took a skeptical view of the cost-saving potential of managed competition. The administration's health plan therefore contained politically controversial caps on national health spending to satisfy the CBO and budget rules. In 2009, though, there is apparently little appetite in Washington for adopting serious, system-wide, explicit cost controls that would generate savings. That puts more pressure on Congress and the administration to identify revenue options that are capable both of passing political muster and of generating substantial funds.

Options that meet both those requirements are hard to identify (see Table 1). Increasing "sin taxes" on tobacco and alcohol does double duty, by raising revenues and reducing consumption of products than can have harmful health effects. Taxing cigarettes has proven an especially popular means for funding health insurance expansions. Public health advocates similarly covet a new federal tax on soft drinks or other high-sugar products in the name of reducing obesity rates.[3] Sin taxes, however, raise only modest amounts of money. Generating more funds requires raising such taxes to levels that are difficult to support politically.

Another tax option is even more controversial. Currently, when employers make payments toward health insurance premiums on behalf of their workers, that contribution is excluded from workers' taxable income. The federal government forgoes $246 billion a year in income and payroll taxes by excluding employer-paid insurance premiums from taxation. Capping that exclusion, either by taxing more expensive health insurance policies or by limiting the exclusion to lower-income persons, would produce substantial revenue. Moreover, capping the exclusion could draw bipartisan support, since this is one tax that Republicans like (largely because they believe that the exclusion promotes "excessive" benefits and inflation of health care costs).

Changes to the tax exclusion, however, face resistance from unions, some employers, and many workers who will not welcome a tax on their health benefits.[4] There also would be serious problems with implementing a cap on the exclusion, including the prospect that persons who are in higher-cost insurance pools (e.g., because their company has an older workforce) could be unfairly penalized. An additional political problem is that not only did President Obama oppose the proposal by Senator John McCain (R-AZ) to end the exclusion during the 2008 campaign, he also promised not to raise taxes on persons making less than $200,000 a year.

Congress will thus have to take the lead if the exclusion is to be modified, though reaching agreement on how to limit the exclusion will be difficult. Still, it is a sign of health care reform's rising prospects — as well as the limited potential of other financing alternatives — that bipartisan support for this option is increasing.

Medicare and Medicaid savings offer an additional financing source (see Table 2). In his 2009 budget plan, Obama called for a total of $316 billion in savings (over 10 years) from these programs to fund health care reform. That included $177 billion from reducing Medicare Advantage payments to private insurers, whose current overpayment makes this a politically attractive savings option.[5] The other Medicare and Medicaid cuts proposed by the administration are

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Table 1. Congressional Budget Office Estimates of Revenues from Selected Options for Financing Health Care Reform.*

Revenue Option	Total Revenue Generated, 2009–2018
	billions of $
Replace income-tax exclusion for employer-sponsored health insurance with a deduction	552.2
Raise cigarette tax by $1 per pack	94.9
Increase alcohol tax to $16 per proof gallon	59.9
Impose tax on sugar-sweetened beverages (3¢ per 12 oz)	50.4
Impose "play or pay" requirement on large employers ($500 tax per employee for not offering health insurance)	48.3

* Data are from the Congressional Budget Office.[2]

Table 2. Congressional Budget Office Estimates of the Effect on Federal Spending of Selected Health Care Reforms.*

Reform	Total Cost or Savings, 2009–2018†
	billions of $
Pay for medical home for Medicare beneficiaries	5.6
Fund comparative-effectiveness research	0.86
Expand Medicare program to pay hospitals on the basis of quality	−2.9
Reduce Medicare payments in high-spending geographic areas	−50.9
Reduce Medicare update factor for hospitals' inpatient payments by 1 percentage point	−92.9
Establish competitive bidding in Medicare Advantage program	−158

* Data are from the Congressional Budget Office.[2]
† Positive numbers are costs, indicating that the reform would increase federal spending by the specified amount; negative numbers are savings, indicating that the reform would reduce federal spending by the specified amount.

moderate enough to be politically feasible. Securing substantially more savings in Medicare and Medicaid, however, could prove difficult. Given the ongoing economic crisis and the states' fiscal straits, Medicaid requires more, not less, federal spending. Medicare offers many opportunities for savings that the CBO will score, but the medical industry will resist additional cuts in program spending.

Finally, health insurance expansions can be financed through employer and individual mandates. Leading Democratic proposals rely on a "play or pay" system that requires employers to either fund health insurance for their workers or pay a tax to help cover the uninsured. Such proposals have important political advantages: they build on the current employer-based system and, to the extent that employers pay for coverage, they privatize health financing. If, however, small businesses are exempted from the play or pay requirement, as Obama and Baucus have suggested, then the revenues produced will be reduced and other means will have to be found to cover uninsured workers in small firms.

Inasmuch as they compel persons whose coverage will not be fully subsidized by the government to purchase insurance, individual mandates are also a funding source. Bipartisan agreement on an individual mandate is feasible, especially since the insurance industry regards mandates as an essential accompaniment to reforms that would limit insurers' ability to engage in medical underwriting. A mandate, though, is only as good as its enforcement mechanism, and a tax penalty for Americans who do not obtain insurance will be controversial. Furthermore, most uninsured persons have low incomes and require government subsidies to obtain coverage, which limits the revenue that an individual mandate can realistically produce.

There is, then, no easy way to pay for comprehensive health care reform. Congressional leaders reacted coolly to the Obama administration's proposal that reform be funded partly by reducing itemized tax deductions (including charitable donations and mortgage interest) for higher-income persons. Yet all the funding options contain various levels of political poison.

Indeed, financing will probably have to be patched together from a combination of controversial sources. If that combination yields less revenue than required, then reformers may have to retreat from the goal of providing all Americans with comprehensive insurance. One possibility for limiting the reform is for Con-

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gress to define a minimum benefit standard with substantial cost sharing for patients, which would reduce federal costs (though it could also ignite a debate over what constitutes adequate coverage). Another approach would be to phase in any expansion of coverage.

Decisions about how to pay for health reform may ultimately hinge on a procedural maneuver. Democratic leaders in Congress, with the prodding of President Obama, have agreed to a budget resolution that allows them to use the reconciliation process to enact health care reform if Congress does not act by October 15 of this year. Reconciliation fundamentally changes the politics of health reform. Legislation considered under reconciliation rules cannot be filibustered in the Senate, meaning that Democrats would need only 51 votes to pass a health care bill, thereby obviating the need for Republican votes. Reconciliation would give Democrats more say over financing, benefit, and cost-control provisions. But it would also mean that Democrats lose bipartisan cover for making controversial choices.

Regardless of who makes the choices, assembling a workable financing plan is an extraordinary challenge. The fate of health care reform in 2009 rests largely on reformers' ability to solve the financing puzzle.

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Medicare and HMOs — The Search for Accountability

Richard Kronick, Ph.D.

Twenty-five years after the introduction of health maintenance organizations (HMOs) as an alternative to fee-for-service Medicare, the promise of these private plans — that competition among them would lead to improvements in the quality and efficiency of health care delivery — remains largely unfulfilled. Some analysts see this failure as a reason to scrap them. However, given the inherent limitations of fee for service, a better solution would be for the new administration and Congress to make one more attempt to extract value from private health plans by holding them accountable for the quality and cost of the care they provide. Establishing accountability is the central challenge of Medicare reform.

Part of the difficulty in reaping rewards from competition among private health plans is that the federal government pays these plans too much. As a result of legislation enacted in 2003 by a Republican Congress enamored of private plans, HMOs and other health plans in the Medicare Advantage program are paid substantially more than Medicare would spend on similar beneficiaries under fee for service (see graph). The Medicare Payment Advisory Commission (MedPAC) has estimated that the overpayment is 14%,[1] or approximately $10 billion in 2008.[2] But the overpayment is almost certainly larger, since this estimate does not take into account health plans' successful efforts to raise their risk-adjusted payment amounts by increasing the number and severity of the diagnoses that they report.[3]

President Barack Obama has strongly advocated reducing payment rates to Medicare Advantage plans, echoing calls made by Democratic congressional leaders and recommendations made by MedPAC. Especially in the context of the looming insolvency of the Part A Trust Fund and the desire to fund health care reform, it is difficult to construct a convincing rationale for paying private plans more than would be paid to fee-for-service providers for care of the same patients.

The Centers for Medicare and Medicaid Services (CMS) has begun the process of reducing payments to Medicare Advantage plans. Rates for 2010 will average 4.0 to 4.5% lower, in nomi-

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