

What Will Healthcare Reform Cost?

BY JANE H. WHITE

The continuing climb of healthcare costs is perhaps the most critical factor driving healthcare reform in the United States. States cannot afford their soaring Medicaid budgets. The federal government, under the Clinton administration, sees control of health spending as a key to turning around its budget deficit problems. Indeed, in 1991 national health spending increased by 11.4 percent from 1990, about four times the growth rate of the general economy.¹

In the private sector, employers and employees find their private insurance rates increasing in double digits, leaving a much smaller share of the pie for salary increases. For small employers, rising costs coupled with recession have led to a decline in health coverage, thus exacerbating the problem of the uninsured population. The percentage of small firms (25 or fewer workers) offering health insurance fell from 39 percent to 32 percent between 1989 and 1991. For firms with 25 to 99 workers, coverage declined from 93 percent to 81 percent over the same period.²

Jon Gabel, director of employee benefits research at KPMG Peat Marwick, argues that, in addition to the recession, "the rising cost of health insurance is equally responsible for pricing small employers out of the market. Since 1988 the cost of employer-sponsored health insurance has increased 75 percent in nominal terms; during these four years medical care prices increased 37 percent, overall inflation increased 19 percent, and average weekly earnings increased 16.7 percent."³

Against this backdrop of rising health costs, Clinton's new healthcare reform plan must control spending as well as increase access to healthcare for the 35 million or so uninsured persons in this country. The question emerges: Can managed competition with its emphasis on managed care really control rising health costs? This column looks at some of the preliminary estimates put forth by both private-sector and government analysts.



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ESTIMATING THE COST OF MANAGED COMPETITION

Estimating the costs and potential savings of a particular healthcare reform plan—before it is announced—is a tricky business. Nevertheless, several Washington-based policy analysts attempted to estimate the cost of managed competition this winter and spring before Clinton released his plan.

Lewin-VHI Estimates Paul Starr, a Princeton sociologist, contracted with Lewin-VHI, a research group based in Fairfax, VA, to estimate the costs of his version of managed competition before he joined the White House task force on health reform. A revised version of these estimates was published in *Health Affairs'* 1993 supplement on "Managed Competition: Health Reform, American Style?"

To produce their estimates, John F. Sheils, Lawrence S. Lewin, and Randall A. Haught of Lewin-VHI first specified a uniform benefit package. Then they estimated the lowest-cost premium for this coverage, based on average costs in a well-managed health maintenance organization (HMO). Next, they determined the cost of premium subsidies and tax revenue effects. Provider reimbursement for Medicaid was assumed to increase to private-payer levels under managed competition. With universal access, however, the researchers assumed hospital uncompensated care costs would be eliminated. "Thus, the net change in provider reimbursement would be an increase of \$27.4 billion (\$39.7 billion in Medicaid increases less \$12.3 billion in uncompensated care savings)," write Sheils and colleagues.⁴

For administrative costs, the Lewin-VHI analysts estimate a savings of \$11.2 billion under managed competition. They add that "it is likely that providers also will see administrative savings stemming from standardization of coverage, although this will be mostly offset by the increased cost of complying with the expanded utilization management programs as is expected under the managed competition model."

Bringing previously uninsured Americans into

a managed competition model might cost \$30.6 billion, estimate Sheils and colleagues. Added to the increase in provider reimbursement of \$27.4 billion, the estimated increase of \$5.6 billion resulting from reduced patient cost sharing, the administrative cost savings of \$11.2 billion, and the estimated savings of \$4.5 billion from increased use of managed care, the total change in national health spending for 1993 would be an increase of \$47.9 billion under managed competition. This figure could drop to \$42.3 billion if the uniform benefit package instituted a higher level of patient cost sharing (\$250 deductible per individual or \$500 per family; 20 percent coinsurance up to maximum out-of-pocket payment of \$2,000 [\$3,000 per family]).

Alternative Estimates In another set of cost estimates, RAND economist Stephen Long and Jack Rodgers, director of policy analysis at Price Waterhouse, offer some alternative numbers. Both Long and Rodgers, while they were at the Congressional Budget Office (CBO), had prepared the original cost estimates for managed competition as envisioned by Alain C. Enthoven, the Stanford University economist who originally conceived the concept. Long and Rodgers argue that "while Sheils and colleagues discuss the incremental effects of total national health spending on a managed competition program, their single estimate for each effect does not reveal the redistributive changes among parts of the health system."⁵

Long and Rodgers estimate the cost of moving to universal health coverage both with and without managed competition. Without managed competition, they estimate, national health spending would increase by \$29 billion in 1993 (about 3 percent) to achieve universal coverage. With managed competition, they project a savings of \$8 billion in national health spending (\$37 billion in savings from managed competition minus \$29 billion to increase health coverage to all Americans).

Differing Assumptions Although the two groups of analysts provide fairly similar projections of the cost of expanding access (\$29 billion versus \$30.6 billion), they differ radically in their estimates of managed competition savings. This large discrepancy is based on differing assumptions of the effect of managed competition on the health-care system. Long and Rodgers, for instance, do not count the \$27.4 billion increase in Medicaid provider reimbursement as an addition to nation-

al health spending. "We choose not to count these additional outlays as added real spending, since they do not correspond to any additional health care services provided and simply reverse cost shifting under the current system," they explain. In addition, Long and Rodgers assume a savings of 8 percent from the shift to managed care or administrative cost reductions, whereas Sheils, Lewin, and Haught assume a 2 percent savings.

Long and Rodgers also estimate the effect of managed competition on the federal deficit. In the first year of reform—before savings effects from managed competition could be realized—federal health spending would increase by about \$52 billion. This results from an increase of \$92 billion in new subsidies for the poor and near-poor, minus spending reductions of \$35 billion for Medicaid, \$5 billion for Medicare, and \$1 billion for Department of Veterans Affairs health costs. Under a scenario where managed competition saves the system 8 percent, the federal government's additional tab would total \$41 billion. With a 16 percent savings, the federal government would still pay \$31 billion more.

These numbers show that the systemwide savings expected by Long and Rodgers will accrue primarily to the private sector, not the public. "The cost of minimizing disruptions to business and of subsidizing the poor and near-poor would necessitate large increases in the federal deficit, or immediate and painful tax increases to avoid them," state Long and Rodgers. "This holds true even under the greatest conceivable savings from managed competition, unless its effects can be extended to include Medicare beneficiaries."

Government Estimates The CBO was also asked to estimate the costs of managed competition as defined in the Managed Competition Act of 1992 (HR 5936). In testimony on February 1, 1993, before the House Ways and Means Subcommittee on Health, CBO Director Robert Reischauer explained that "after a few years, HR 5936 would leave national health expenditures at approximately the same level they would otherwise reach." Initially spending would increase, since comprehensive health benefits would be extended to a larger number of people.

A key question that affects assumptions of managed competition savings is, How much can we really save by shifting to more managed care coverage? Reischauer testified, "If everyone were required to enroll in a staff or group-model

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HMO—the only type of managed care that has to date been demonstrated to achieve substantial savings—CBO estimates that national health expenditures could decline by as much as 10 percent.” However, even with this savings, healthcare costs would still rise in subsequent years, “since there is no evidence that even effective HMOs have been successful at reducing the rate of growth of health spending,” Reischauer continued.

In testimony one month later (March 2) before the same subcommittee, CBO’s Reischauer also addressed the question of whether health reform would reduce the federal budget deficit. The Clinton administration is projecting a deficit savings from healthcare reform of about \$200 billion in 10 years. Reischauer cautioned, however:

The notion that reforming the system will quickly yield significant savings on the spending side of the federal budget is probably optimistic. Fundamental reform of the system is obviously essential if the growth in health costs is to be stemmed in the long run. But in the short run—say, over the next 10 years—it will be exceedingly difficult to realize significant budgetary savings as long as any reform proposal extends coverage to the uninsured, reduces the high costs facing privately insured people, and maintains all of the other desirable aspects of the current system.

SHORT-TERM COST SAVINGS

To achieve healthcare cost savings in the short-term (before the next presidential election), Clinton will need to institute cost controls beyond his plan of managed competition. Alternatively, he could phase in the coverage for the uninsured, to lessen the cost to the system. However, that alternative may also be politically unacceptable.

A leaked memo to Health Care Task Force members from Clinton’s adviser for policy development, Ira Magaziner, outlines some options the task force explored for controlling health system costs:

1. Various means to institute cost controls.
2. Ways to extend Medicare rate regulation to private insurance systems or to institute some other form of all payer rate regulation.

A tax on providers is likely to appeal to Congress and administration policymakers as an “easier” target than taxing individual Americans’ payroll or health benefits.

3. Ways to accelerate the move to managed competition within a budget.

4. Ways to introduce global budgets or caps soon even if managed competition takes more time to phase-in.

5. Ways to elicit voluntary controls from the health care industry.

6. Ways to provide incentives for states and private entities to manage care more efficiently.

7. Ways to use tax incentives or penalties to influence utilization and price of health care services.

8. Other means not yet identified to control costs.⁶

Magaziner acknowledges that most health reform savings will accrue to the private sector. Some possibilities he outlines for recapturing savings to help reduce the federal deficit include:

- Allowing insurance premiums to go up somewhat faster than intended and taxing the premiums.
- Raising a corporate tax to capture part of the savings corporations will realize from slower premium growth.
- Taxing benefit plans offering coverage above a certain level.
- Reducing uncompensated care payments.
- Instituting higher taxes on alcoholic beverages, tobacco products, pollutants, guns or other products which contribute to health problems.
- Creating a tax on noncritical service usage.

Taxes Obviously, a number of new taxes are under consideration for financing health reform. Sheils, Lewin, and Haught of Lewin-HIV estimated the potential revenue available from a variety of new taxes:

- \$4.08 billion from an 8-percent payroll tax on part-time workers
- \$11.87 billion from taxing the employer contribution over 75 percent of the low-cost health plan
- \$3.17 billion from a 1 percent tax on hospital revenue
- \$33.85 billion from a new 1 percent tax on earnings

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CARE OF THE DYING

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their last days in as peaceful and uncomplicated a fashion as possible.

Institutional Ethics Committees An institutional ethics committee can be a valuable resource in making difficult ethical decisions. As a forum for ethical reflection, dialogue, and planning, this multidisciplinary group serves the institution by promoting education, assisting in the development of policies, consulting in difficult situations, and providing a forum for the resolution of difficult cases, thereby avoiding recourse to the courts.

Educating the Public Developments in medicine, especially advances in the use of technology, drug therapies, and surgery, have captured the interest of the public. Recent court rulings have added to the growing concern about the use of these medical advances to prolong life. More people want to learn about the proper use of advanced technologies to sustain life. Healthcare institutions can make a significant contribution to preventive medicine by sponsoring more educational programs.

Hospice A comprehensive philosophy of care for people in the final phases of a terminal illness, hospice affirms life and regards dying as a normal process. Hospice emphasizes controlling pain and symptoms to enhance the quality of life rather than to cure an illness or extend life. Hospice allows patients and their families to live each day as fully and comfortably as possible and assists in dealing with the stress caused by illness, death, and grief. Hospice uses a team approach to focus on the physical, emotional, spiritual, and

social needs of patients and their families. The interdisciplinary team of physicians, nurses, aides, social workers, trained volunteers, and pastoral counselors provides coordination and continuity of patient and family care and also offers follow-up services and grief counseling for the family after the patient has died.

Adequate reimbursement for hospice services is a public concern and is currently being addressed by legislators and third-party payers. Improved education of healthcare professionals, the religious community, and the general public about the availability, appropriate referral, and correct utilization of hospice services is necessary to improve awareness and to ensure high-quality care for dying patients and their families.

APPROPRIATE CLINICAL CARE FOR DYING PATIENTS

By providing appropriate care to dying patients in clinical settings, care givers seek to respect patients' integrity as persons through the final days of life. Through appropriate clinical care, care givers try to guarantee patients will:

- Be kept as free of pain as possible so they may die comfortably and with dignity
- Receive continuity of care and not be abandoned or lose personal identity
- Retain as much control as possible over decisions regarding their care and be allowed to refuse further life-prolonging technological interventions
- Be heard as individuals with personal fears, thoughts, feelings, values, and hopes □

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- \$5.06 billion from a 1 percent surtax on personal income tax
- \$935 million from a 1 percent surtax on corporate income tax
- \$772 million from a 10 percent increase in the tax on alcoholic beverages
- \$5.13 billion from doubling the tax on tobacco products
- \$523 million from increasing the gasoline tax by 1 cent per gallon.⁷

Among these options, the tax on providers is likely to appeal to Congress and administration policymakers as an "easier" target than taxing payroll or health benefits of individual Americans. Many in the Congress still remember their hasty retreat from requiring wealthy seniors to foot a larger share of the bill for Medicare catastrophic coverage after the outcry of elderly constituents.

Whether a provider tax and others under consideration are politically viable for Congress and the American people remains to be seen. This month the health reform ball now moves from the administration to the open forum of Congress for debate and action. For policymakers and the public alike, the cost of reform and how it will be financed will be crucial questions for the viability of the president's health reform proposal. □

NOTES

1. Suzanne W. Letsch, "National Health Care Spending in 1991," *Health Affairs*, Spring 1993.
2. Jon R. Gabel, "Witness to a Thousand Stories: A Look at Insurance Data," *Health Affairs*, Winter 1992, pp. 186-190.
3. Gabel.
4. John F. Sheils, Lawrence S. Lewin, and Randall A. Haught, "Potential Public Expenditures under Managed Competition," *Health Affairs*, Suppl., March 1993, pp. 229-242.
5. Stephen H. Long and Jack Rodgers, "Managed Competition Estimates for Policy Making," *Health Affairs*, Suppl., March 1993, pp. 243-247.
6. Ira Magaziner, "Memorandum for the First Lady and Chairperson, Health Care Task Force," January 26, 1993.
7. Sheils et al.