

Impacts of Health Care Reform:

PROJECTIONS OF COSTS AND SAVINGS



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by

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A Report Prepared for the National Coalition on Health Care



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Foreword

The non-partisan National Coalition on Health Care is the nation's largest and most broadly representative alliance of major organizations working together for system-wide health care reform, including health insurance for all Americans, cost management, and improved quality of care. Our member organizations — companies, unions, associations of health care providers, patient and consumer groups, insurers, religious organizations, and pension and health funds — collectively represent about 150 million Americans.

In July 2004, after a year of study and deliberations, the Coalition issued a major report about the crisis in health care — including surging costs, a huge and growing number of Americans without insurance, and an epidemic of sub-standard care — and about what should be done. That report — entitled *Building a Better Health Care System: Specifications for Reform* — set out objectives for health care reform, criteria by which alternative proposals can be assessed, and recommendations and options for policymakers and the public to consider. Our hope was, and is, to help frame and accelerate a much-needed debate about national health care policy and to map out a path forward.

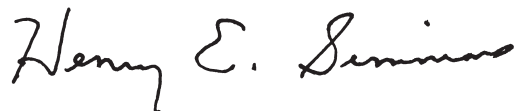
Recently, the Coalition commissioned an independent assessment — by a highly respected health care economist, Professor Kenneth Thorpe of Emory University — of the costs and savings that would be associated with health care reform along the lines commended by our members. Using conservative assumptions, Professor Thorpe modeled the impacts of four scenarios consistent with the Coalition's specifications.

He found that in all four scenarios, the cost of a reformed system would be less — much less — than the cost of continuing with the

status quo. Even after taking into account the costs of assuring universal coverage, annual system-wide savings would be between \$125 billion and \$182 billion in the tenth year of implementing reform. Cumulative savings for that same ten-year period would range, across scenarios, from \$320 billion to \$1.1 trillion.

The benefits of health care reform go well beyond these direct dollar savings. System-wide reform, as called for by the Coalition, would insure that every American has health insurance, save lives and reduce unnecessary injuries by improving the quality of care, and help to safeguard and advance economic growth and living standards.

America can afford health care reform. What we cannot afford is a continued failure to address the crisis in health care.

A handwritten signature in black ink that reads "Henry E. Simmons". The signature is written in a cursive, flowing style.

Henry E. Simmons, M.D., M.P.H., F.A.C.P.
President, National Coalition on Health Care

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The National Coalition on Health Care is an alliance of large companies, unions, health and pension funds, associations of health care providers, patient and consumer groups, insurers, and religious organizations. In a report entitled *Building a Better Health Care System: Specifications for Reform*, the Coalition offered a diagnosis of the problems of the American health care system and a set of prescriptions to address them. Those prescriptions — which the Coalition termed specifications for reform — consist of objectives, criteria, and options for health care reform that the members of the Coalition support and have advanced to frame and accelerate the national debate about health care policy.

The analysis below summarizes the Coalition's recommendations and then estimates their likely impacts on national health care spending and federal costs. These estimates have been constructed using methodology that has previously been applied by the author in projecting the effects of other health care policy programs.

A. Summary of the Coalition's Specifications

This section outlines the specifications recently developed by the National Coalition on Health Care. The Coalition's report addresses a much broader range of reforms than those described below. The summary presented here focuses on the elements of reform likely to result in changes in health care spending by the federal government, employers, or employees. The headings that follow correspond to the five principles that the Coalition's specifications are meant to further.

1. Health Care Coverage for All

The Coalition urges that every American¹ be assured health care coverage within two to three years after the enactment of legislation. The Coalition's report sets out elements of a core benefit package that would constitute the base coverage to be provided. The Coalition identifies a range of what it characterizes as viable options for insuring all Americans:

- **Scenario 1:** employer mandates (supplemented with individual mandates as necessary);
- **Scenario 2:** expansion of existing public programs that cover subsets of the uninsured;
- **Scenario 3:** creation of new programs targeted at subsets of the uninsured, and
- **Scenario 4:** establishment of a universal publicly financed program.

The Coalition recommends that subsidies be provided toward the cost of insurance for those who are less affluent.

2. Cost Management

The Coalition also recommends reducing the annual growth in the health care costs and insurance premiums associated with the core set of covered services to approximate equivalence with annual growth in per-capita gross domestic product (GDP). The Coalition calls for this goal to be reached within five years after the enactment of legislation. The Coalition outlines a variety of policy changes designed to reduce the growth in health care spending, including constraints on payments to health care providers and explicit limits on increases in health insurance premiums.

¹ The Coalition does not offer a precise definition of this phrase. For our estimates, we include all legal residents in the United States even if they are not currently citizens. Such residents are eventually eligible for Medicaid (after a waiting period) under current law.

Several features of the NCHC proposal, in conjunction with those constraints on reimbursement and premiums, would assist in reducing the growth in spending. First, faster diffusion of computerized physician order entry (CPOE) and other patient safety interventions would reduce administrative costs and overall spending. Today, only 15 percent of hospitals have installed this new technology. Second, the broader application of disease management and redesign of our health care delivery system would increase value and for some categories of care (such as treatment of congestive heart failure) actually reduce spending. Savings associated with these aspects of the NCHC proposal are not analyzed separately below, but are assumed to work in combination with the constraints on reimbursement and premiums to limit spending increases to per capita growth in gross domestic product.

3. Improvement of Health Care Quality and Safety

The Coalition's report calls for a multifaceted national strategy for improving the safety and quality of health care in America, including investment in the generation and dissemination of new information about the effectiveness and cost-effectiveness of health care interventions. Efforts would be made to reduce the variations in clinical treatments of patients. The Coalition also proposes measures to accelerate the development of a national information technology infrastructure (including automated clinical information systems, electronic patient records, and computerized physician order-entry systems). Studies have found that use of CPOE produces a 28 to 55 percent reduction in preventable prescribing errors.² CPOE is currently available in about 15 percent of all hospitals and costs about \$3 to \$10 million per installation.³

The Coalition's specifications seek to speed up the diffusion of these new technologies. Over the next ten years, electronic prescribing and billing will be nearly universal. Today, about 40 percent of the nearly

² D.W. Bates, et al. "Relationship between Medical and Adverse Drug Events" *Journal of General Internal Medicine*, 19 (1995): 199-205. D.W. Bates, et. al. "Effect of a Computerized Physician Order Entry and Clinical Support Systems on Medication Safety: A Systematic Review", *JAMA* 280 (15) 1998 1311-1316

³ E. Poon, et. al. "Overcoming Barriers to Adopting And Implementing Computerized Physician Order Entry Systems in U.S. Hospitals" *Health Affairs*, July/August 2004: 184-189.

18 billion transactions that occur in the health care system are still on paper. If the industry moved to electronic billing, claims adjudication, and remittance today, we could save about \$30 billion in administrative costs. Estimated savings associated with the Coalition's recommendations represent the difference between how fast the use of electronic transactions is spreading currently and the rate of diffusion anticipated under those recommendations.⁴ The faster diffusion of electronic billing and remittance would reduce national health spending by \$12 billion over the ten-year period of our projections.

Several other aspects of the NCHC proposal would also generate savings while improving the quality of care and protecting the safety of patients. Developing precise estimates of those savings is difficult. In particular, the Coalition has proposed that a new national board be responsible for coordinating the development of national practice guidelines. An increasing volume of published research highlights the high costs associated with poor quality health care. Improving the quality of care would reduce health care spending and improve patient outcomes. Some estimates indicate that health care spending could fall by nearly a third through the reduction of overuse, misuse, and waste.⁵ These initiatives to improve quality would be an important set of tools for purchasers to slow the growth in health care spending.

4. Equitable Financing

The Coalition identifies a range of mechanisms that could be used to fund the costs associated with the initiatives it calls for, including the costs of subsidies to assure health care coverage for all Americans. The Coalition also recommends that reform seek to reduce or eliminate cost-shifting (i.e., differences across insurance programs and insurers, both public and private, in reimbursement rates of payments relative to costs). In our estimates, we assume that increases in Medicaid payments would be phased in to cover the cost of services beginning in 2010.

⁴ The Coalition's recommendations envision a mix of federal financial incentives to accelerate diffusion. For illustration, I have assumed that such incentives would cost about \$6 billion over the next ten years.

⁵ These studies are summarized in Midwest Business Group on Health, *Reducing the Costs of Poor-Quality Health Care Through Responsible Purchasing Leadership*, 2003. The magnitude of the potential cost reductions cited in this study through quality improvement initiatives included in the Coalition proposal are similar to those suggested by Don Berwick, David Lawrence and Brent James.

5. Simplified Administration

As described above, the Coalition’s specifications call for a variety of measures — including the definition and use of a core benefit package and the development of an integrated national information technology infrastructure — that would reduce the complexity and the administrative costs of the health care system.

B. Estimates of the Changes in Health Care Spending Associated with the Coalition’s Specifications

1. Assumptions

This section presents estimates based on a set of assumptions, described below, that are consistent with the Coalition’s specifications. Savings and cost projections reflect the operations of the specifications collectively for each of four scenarios, corresponding to the four options that the Coalition has identified for extending health insurance to all Americans.

The estimates developed for this report assume the following:

- The core set of benefits described in the Coalition’s specifications would be similar in scope and actuarial value to what employers typically provide their workers today. As a proxy for this coverage, we use the benefit design provided by the Blue Cross and Blue Shield Association’s standard option plan in the Federal Employees Health Benefits Program (FEHB).

We assume for purposes of these calculations that all uninsured adults at or below 150 percent of the Federal Poverty Level (FPL) would be enrolled in Medicaid. In turn, most Medicaid programs have enrolled children and adults in private health care plans. In our estimates, we do not distinguish between Medicaid enrollment and enrollment in private insurance; we assume for both the same per capita cost, based on current Medicaid spending and adjusted for the demographics of the newly insured.

- Workers would be expected to pay 25 percent of the cost of their health insurance premiums. That share of costs would be scaled by income. Those at 151 percent of the FPL would not contribute; families earning 300 percent of the FPL or above would pay the full 25 percent share. The federal government would assume responsibility for the remaining portion of the 25 percent premium share for workers in families with incomes between 151 and 300 of the FPL.
- Employers would pay 75 percent of the premium for each of their workers. For the fourth scenario — a universal publicly financed program — we assumed that employers would pay 75 percent of the total payroll tax contribution used to finance the plan and that workers would be responsible for the remainder.
- The self-employed would pay 100 percent of their premiums. Those with incomes at or below 150 percent of the FPL would not contribute toward the cost of insurance; those with incomes from 151 to 225 percent of the FPL would pay 50 percent of premiums; and those above 300 percent of the FPL would pay 100 percent.
- Employers that currently offer health insurance benefits less generous than the core benefit package (again, assumed to reflect the typical offerings of employers today) would upgrade their benefits to this standard.⁶
- Under the Coalition’s specifications, universal coverage would be achieved within three years after the passage of legislation. Our projections assume that in this time frame uncompensated care costs passed on by providers to private health care plans would be virtually eliminated. Today, private health plans pay

⁶ We assume that employers would have to meet a test of equivalent actuarial value for the core benefit package. Based on previous work, we have sorted the actuarial values of private health insurance plans and created a distribution. By assumption, the median plan is the core benefit, and its per capita cost in 2006 dollars is about \$4000. Employers with plans in the 25 to 50 percentile distribution of actuarial values would have to increase their current spending by about 10 percent, and plans below that level by about 20 percent. These increased levels of spending would be associated with employers broadening benefits, reducing worker cost sharing, or both.

about 113 percent of the costs associated with treating their patients.^{7,8} We assume that these payment rates would be reduced to rates closer to the costs of treatment.

In addition, as noted, we assume that beginning in 2010, payment rates for Medicaid services would begin to rise closer to the actual costs of treatment. According to the Medicare Payment Advisory Committee (MedPac), Medicaid (on average) pays hospitals rates close to the actual costs of treatment (including disproportionate share payments). On the other hand, several studies have estimated that Medicaid pays physicians at about 50 percent of actual treatment costs. These ratios of physician payments to costs vary widely across states.⁹

- As discussed above, the projections developed for this report encompass all five elements of the Coalition’s specifications; we have modeled the operations of these elements collectively. With respect to one of these five components — the attainment of health coverage for all Americans — the Coalition has set out four scenarios. In modeling the costs and savings associated with each of those scenarios, we have in effect held constant the impacts of other pertinent provisions in the specifications.
- For the third scenario — the creation of new programs targeted at subsets of the uninsured — we have posited the establishment of a program modeled on the Federal Employee Health Benefit Program. For the fourth scenario — the development of a universal publicly financed program — we have assumed, for purposes of modeling, that moneys now paid in the form of premiums for coverage to the extent of the core benefit package would flow instead to and through a universal program in the form of payroll tax payments. This assumption is consistent with a variety of alternative arrangements for coverage

⁷ Medpac, Report to the Congress: Medicare Payment Policy , March 2003, Table D-13, p 278.

⁸ Direct Research LLC, Medicare Physician Payment Rates Compared to Rates Paid by Average Private Insurers, 1991-2001. Report to the Medicare Payment Advisory Committee, August 2003.

⁹ The Lewin Group, “The American College of Emergency Physicians (ACEP) Practice Expense Study”, for the American College of Emergency Physicians, September 15, 1998.

itself, including the possibility that the funds generated through a payroll tax would be used to secure coverage exclusively or primarily from private and non-profit insurers.

2. Methods

Our estimates are based on a micro simulation model of the U.S. health care system that has been used in several previous estimates of the impacts of health care reform proposals. The model uses data from several sources, starting with the March 2004 Current Population Survey (CPS). Information on health insurance spending is derived from data in the 2001/2002 Medical Expenditure Panel Survey (MEPS). The data from the MEPS are statistically matched to the industry, age, family structure, income, and other demographic measures of those in the CPS survey. Information on base-line spending for the Medicare and Medicaid program are from the most recent projections by the Congressional Budget Office (CBO).

3. Results

Impacts on National Health Care Spending

System-wide health care reform, along the lines that the Coalition's specifications envision, would produce substantial reductions in national health care spending — reductions that would begin soon after reforms were phased in and that would increase over time.

As projected by the Centers for Medicare and Medicaid Services (CMS), national health care spending would be expected to rise under current law — that is, in the absence of major health care reform — from nearly \$2.1 trillion in 2006 to more than \$3.8 trillion in 2015. That means that the proportion of our gross domestic product devoted to health care spending would jump from about 15.6 percent now to 19 percent in 2015 — an increase of 3.4 percentage points.

Tables 1 and 2 display what the trajectory of national health care spending would be if we were to undertake the reforms recommended by the NCHC. In Scenarios 1 through 3, savings would begin in the fourth year of implementation — 2010 — and rise

every year thereafter. In 2015, annual savings would range from \$125 billion to about \$131 billion; total savings in the first decade of reform — even after taking into account the increases in federal spending needed to secure universal coverage — would amount to between \$320 billion and \$369 billion. In Scenario 4, savings would begin in the first year of implementation and would be about \$182 billion in 2015; total savings in the first decade of implementation would exceed \$1.1 trillion.

Table 1. Projections of National Health Care Expenditures Under Current Law and Four Coalition Scenarios, 2006-2015 (Billions of Dollars)

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
National Health Expenditures	\$2077.5	\$2232.9	\$2399.2	\$2573.3	\$2753.9	\$2944.2	\$3146.3	\$3360.7	\$3585.7	\$3839.9
Coalition Scenario 1	\$2087.9	\$2260.6	\$2435.1	\$2588.5	\$2705.2	\$2918.1	\$3099.1	\$3291.0	\$3493.3	\$3714.3
Coalition Scenario 2	\$2087.9	\$2260.6	\$2435.1	\$2588.5	\$2705.2	\$2918.1	\$3099.1	\$3291.0	\$3493.3	\$3714.3
Coalition Scenario 3	\$2085.0	\$2256.0	\$2430.0	\$2583.0	\$2700.0	\$2914.0	\$3094.0	\$3286.0	\$3487.0	\$3709.0
Coalition Scenario 4	\$2052.5	\$2175.9	\$2309.2	\$2473.3	\$2642.9	\$2821.2	\$3010.3	\$3211.7	\$3422.7	\$3657.9

SOURCE: Centers for Medicare and Medicaid Services, NHE projections, February 2005

Table 2. Changes in Spending Under NCHC Specifications (Billions of Dollars)

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total
Coalition Scenario 1	10.4	27.7	35.9	15.2	-48.7	-26.1	-47.2	-69.7	-92.4	-125.6	-320.5
Coalition Scenario 2	10.4	27.7	35.9	15.2	-48.7	-26.1	-47.2	-69.7	-92.4	-125.6	-320.5
Coalition Scenario 3	7.5	23.1	30.8	9.7	-53.9	-30.2	-52.3	-74.4	-98.7	-130.9	-369.6
Coalition Scenario 4	-25.0	-57.0	-90.0	-100.0	-111.0	-123.0	-136.0	-149.0	-163.0	-182.0	-1136.0

Impacts on Spending by Employers and Families with Health Insurance Now

Health care reform in furtherance of the Coalition’s specifications would also produce significant reductions in private spending on health insurance. Constraining the growth in the costs and premiums for services covered by the core benefit package — to bring that rate down to approximately the rate of increase in per capita gross domestic product — would effectively produce a 3.5 to 4 percentage point reduction in the rate of growth in private health insurance spending.

In any of the Coalition’s first three scenarios, employers providing health insurance today would collectively save about \$848 billion during the ten-year period analyzed here. Their cumulative savings under the fourth scenario would amount to about \$595 billion.

Families with private health insurance now would also save substantial sums in a reformed system — about \$309 billion collectively over ten years in Scenarios 1, 2, or 3 and about \$195 billion in Scenario 4.

Table 3. Changes in Health Insurance Spending Among Employers That Currently Offer Health Insurance (Billions of Dollars)

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total
Total Private Health Insurance Spending Under Current Law	\$722.0	\$775.4	\$834.2	\$895.7	\$957.4	\$1022.7	\$1088.5	\$1156.8	\$1224.8	\$1313.0	\$9990.5
Employer Private Health Insurance Spending Under Current Law	\$512.6	\$550.5	\$592.3	\$635.9	\$679.8	\$715.9	\$762.0	\$809.8	\$857.4	\$919.1	\$7035.2
Changes in Employer Private Insurance Spending (Billions of Dollars)											
Coalition Scenario 1	0.1	-11.3	-30.6	-49.8	-69.3	-90.2	-110.0	-131.2	-160.7	-195.0	-848.0
Coalition Scenario 2	0.1	-11.3	-30.6	-49.8	-69.3	-90.2	-110.0	-131.2	-160.7	-195.0	-848.0
Coalition Scenario 3	0.1	-11.3	-30.6	-49.8	-69.3	-90.2	-110.0	-131.2	-160.7	-195.0	-848.0
Coalition Scenario 4	-11.5	-19.2	-28.7	-39.1	-49.7	-62.2	-74.9	-88.3	-101.0	-121.2	-595.8

Table 4. Changes in Health Insurance Spending Among Families That Currently Have Health Insurance (Billions of Dollars)

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total
Worker and Household Private Health Insurance Spending Under Current Law	\$209.4	\$224.9	\$241.9	\$259.8	\$277.6	\$306.8	\$326.6	\$347.0	\$367.4	\$393.9	\$2955.3
Changes in Spending for Workers Insured Today (Billions of Dollars)											
Coalition Scenario 1	0.2	-38	-11.0	-18.2	-25.4	-33.2	-40.6	-48.4	-59.4	-69.5	-309.3
Coalition Scenario 2	0.2	-38	-11.0	-18.2	-25.4	-33.2	-40.6	-48.4	-59.4	-69.5	-309.3
Coalition Scenario 3	0.2	-38	-11.0	-18.2	-25.4	-33.2	-40.6	-48.4	-59.4	-69.5	-309.3
Coalition Scenario 4	-0.4	-6.4	-9.6	-13.0	-16.6	-20.7	-24.9	-29.4	-33.7	-40.4	-195.1

Impacts on Federal Spending

As indicated in Table 5, under the first three scenarios for assuring health insurance to all Americans, subsidies for lower-income Americans and, to a lesser extent, adjustments in Medicaid reimbursement rates would cost an average of about \$100 billion per year over the first decade of implementation. However, the net increase in federal spending would average about \$75 billion per year — a total of about \$750 billion in the first decade of implementation — after taking into account two offsets. First, universal coverage would reduce the dollar volume of uncompensated care, producing in turn a reduction in disproportionate share payments under Medicare and Medicaid. Second, some of the savings that employers would realize in a reformed system would be passed back to employees in the form of higher wages, which in turn would generate additional revenue — from income and payroll taxes — for the federal government.

Scenario 4 — which would involve the creation of a universal publicly financed program — is, for these calculations, a special case. In this scenario, employers and employees who now pay premiums for health insurance would stop paying premiums and instead

would contribute payroll taxes toward the cost of coverage. Table 1 reflects, for Scenario 4, this redirection of premium dollars.

**Table 5. Net Federal Spending Under NCHC
Specifications in Billions, FY 2006-2015**

	Scenario 1	Scenario 2	Scenario 3	Scenario 4
New Spending	\$1,013	\$987	\$1,013	\$8,161
Offsets				
Disproportionate Share Savings	(\$157)	(\$157)	(\$157)	(\$157)
Higher Indirect Tax Receipts Linked to Employer Savings	(\$90)	(\$90)	(\$90)	(\$100)
Payroll Tax Receipts	\$0	\$0	\$0	\$7,883
Totals	\$766	\$740	\$766	\$21

In sum, a reformed health care system — reformed, that is, along the lines recommended by the members of the National Coalition on Health Care — would cost our nation much less money than an unreformed system. What should also be clear from this analysis is that a reformed system would produce more value than an unreformed system — by guaranteeing health insurance for all Americans, by increasing the efficiency of the health care sector, and by improving the quality and safety of the care that patients receive.

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