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Options for Financing Health Reform: Comparing the Impact of Selected Policy Options

Synopsis

A number of policies have been proposed to expand health insurance coverage and improve health system performance in a financially sustainable way. To illustrate how the potential impact of such reforms depends heavily on the details and structure of the reforms, the authors examine estimates from three sources: a recent Commonwealth Fund report containing projections prepared by The Lewin Group; the Office of Management and Budget; and the Congressional Budget Office. Estimates from all three sources indicate that early investments in reform could yield significant reductions in total health care spending over time through gains in the quality and efficiency of care.

Background

In President Obama's first budget to Congress, he outlined his administration's priorities for health reform: protecting families' financial health; ensuring that health coverage is affordable; aiming for universality in coverage; providing portability of coverage; guaranteeing consumer choice; investing in prevention and wellness; improving patient safety and the quality of care; and maintaining long-term fiscal sustainability.[1] Consistent with the president's belief that health reform should be financially sustainable and deficit-neutral, he included a $634 billion reserve fund to advance reforms over the next decade and proposed $313 billion in additional savings in a June 2009 addendum.[2] The budget proposal builds on the $150 billion investment included in the economic stimulus package—the American Recovery and Reinvestment Act (ARRA), enacted in February.[3] In a departure from the past, the administration has left the details of the health reform legislation to Congress, looking primarily to the committees of jurisdiction to develop legislation consistent with its goals.

A wide range of policy options exist for achieving health system savings to help finance health reform. In the Commonwealth Fund report, *Finding Resources for Health Reform and Bending the Health Care Cost Curve*, the authors compared impact estimates of selected options from three different sources: 1) The Commonwealth Fund report, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (Path), which included projections prepared by The Lewin Group; 2) the Office of Management and Budget (OMB), for the president's budget proposal and the economic stimulus bill; and 3) the Congressional Budget Office (CBO).[4] All estimates consider the potential impact over the 10-year period, 2010 to 2019. The OMB and CBO estimates focus only on the projected effect on federal spending and do not estimate the potential impact on total national health expenditures (NHE). The Path report, meanwhile, looked at potential savings in terms of both the federal budget and national health spending—in order to illustrate the impact on state revenues, employers, and households.

Estimates from all three sources indicate that early investments could yield significant reductions in total health care spending over time through gains in the quality and efficiency of care. The differences among the estimates reflect primarily the scope of the policies and their particular elements. The table below summarizes OMB/ARRA, CBO, and Path estimates for various policy options (refer to the full report for more detail on each of the selected policy options.)

In this *Policy Points* brief, we focus on two of the savings options: bundling hospital payments to include acute-care services and annual productivity adjustments, and comparative effectiveness research.

Potential Sources of Federal Savings and Revenue Compared with Projected Trends, Cumulative, 2010–2019

	OMB: Budget and ARRA	CBO	Path (Federal)	Path (Total Health System)*
Savings	*$ Billions*	*$ Billions*	*$ Billions*	*$ Billions*
Revision of Medicare Advantage Benchmarks	175	157/158	135	—
Reduction of Prescription Drug Costs	29 / 75	110	93	62
Hospital Payment Reform: Paying for Episodes of Care, Including Post-Acute Care and Incorporating Productivity Adjustments into Payment Updates	26/110	19/201	123	182
Modified Home Health Update Factor	37	50	—	—
Hospital Pay-for-Performance	12	3	43	55
Promotion of Patient-Centered Medical Homes	—	(6)	83	144
Primary Care Payment Reform	—	5	23	56
Adoption of Health Information Technology	13	4/61	70	180
Comparative Effectiveness Research and Use of Information	—	(1)	174	480
Modified High-Cost-Area Update	—	51	100	177
Reduced Subsidies to Hospitals for Treating Uninsured as Coverage Increases	106	—	9	—
Managed Physician Imaging	—	1/3	23	29
Modified Updates for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, and Long-Term Care Hospitals	—	24	—	—
Reduce Waste, Fraud, and Abuse	—	0.5	—	—
Select Population Health Options				
Tobacco Excise Tax	—	95	79	215
Alcohol Excise Tax	—	60	47	—
Sugar-Sweetened Beverage Excise Tax and Obesity Abatement	—	50	121	321

Notes: Savings are not additive and policies may have overlapping or synergistic effects. If Lewin did not provide any estimate for a policy or only provided an estimate of impact to the federal budget, the Total Health System column is left blank.

Bundling Payments for Hospitals: Inclusion of Post-Acute Care and Productivity Adjustments in Payment Updates

The Medicare fee-for-service program currently pays hospitals fixed amounts for each hospital admission/discharge based on the diagnosis and adjustments for level of risk. Paying a bundled rate for the inpatient hospital stay up to the time of discharge creates an incentive for hospitals to provide efficient care over the course of the hospitalization. But this alone will not support incentives for hospitals to help patients during their transition to home or to post-acute care settings, nor will it ensure that patients receive follow-up care—essential for avoiding serious complications that can lead to costly rehospitalizations. One way to align incentives, provide better care for vulnerable patients, prevent readmissions, and lower health care costs would be to expand the scope of bundled payments to encompass acute hospital care and post-acute care and hold hospitals accountable for the costs of the initial hospitalization and readmissions.

- **OMB options:** 1) Bundle hospital payments for inpatient acute care and targeted post-acute care providers for 30 days after hospitalization, yielding $8 billion from fewer readmissions and $18 billion from increased efficiency in post-acute care ($26 billion federal savings); 2) permanently adjust Medicare payment updates by half of the expected productivity gains, to encourage greater efficiency in the provision of care while better aligning Medicare payments with provider costs ($110 billion federal savings).

- **CBO options:** 1) Bundle hospital payments for inpatient acute care, readmissions, and post-acute care within 30 days of discharge, allow hospitals to retain 20 percent of anticipated savings, and recapture the remaining savings through adjustments to annual update factors ($19 billion federal savings); 2) reduce Medicare payment updates by the entire expected productivity gain to encourage greater efficiency and better align payments with provider costs ($201 billion federal savings).
- **Path option:** Phase in bundled hospital payments for inpatient acute care to include readmissions, then post-acute care received within 30 days of discharge, and finally inpatient physician services; reduce annual update factors over time to reflect increased productivity ($123 billion federal savings, $182 billion total health system savings).

Comparison

The differences among the three estimates of savings stem from the scope of and approach to bundling, as well as from policies related to payment updates. The CBO estimate assumes the expanded bundled payment rate would be updated with the current update factors, less the savings adjustment, while The Lewin Group (Path option) estimate includes annual decreases to the update factors. Without this reduction, Lewin estimates that bundling would yield $74 billion in federal savings. In addition, the Path option would be applied to the Medicare program and a new public health insurance plan option offered to the under-65 population through a national insurance exchange. In contrast, the Obama administration's budget option and the CBO option would only apply to Medicare. Of the net $182 billion saved through this option, Lewin estimates $115 billion would come from Medicare savings.

Comparative Effectiveness

As medical science evolves, better information on the effectiveness and comparative effectiveness of available treatment options, medications, and devices is essential to support decision-making by providers and patients, as well as payers. Better evidence is important both for existing treatment alternatives and for new treatments and technology. An objective source of clinical information about what is likely to work well for particular patients would improve the quality of care, and approaches that synthesize information about treatments and outcomes also would help inform patients about their care options. Investments in generating better information for health care decision-making, combined with incentives to encourage more effective use of available information, could reduce unnecessary care, increase the provision of appropriate care, and improve the management of chronic conditions. Information about the relative costs of similarly effective care options could further inform decisions—and potentially control costs over time while improving health care quality and outcomes.

- **ARRA provision:** Appropriates $1.1 billion for investment in comparative effectiveness activities, including $400 million for the Secretary of Health and Human Services to conduct, support, or synthesize comparative effectiveness research and encourage the development and use of infrastructure and systems to generate or obtain outcomes data, and establishes an interagency advisory panel to coordinate and support such research (no estimate of savings available).
- **CBO option:** Fund comparative effectiveness activities, beginning with a $100 million investment in 2010 and growing to $400 million in 2014; funding would remain at that level through 2019 ($1 billion increase in federal spending, $8 billion total health system savings).
- **Path option:** Create a new Center for Comparative Effectiveness Research and Health Care Decision-Making responsible for conducting and synthesizing comparative effectiveness research and link research findings to public and private insurance payment and benefit design policies; also, support the use of decision aids designed to inform patients of alternative treatment options, including information about differential cost-sharing and relative pricing ($174 billion federal savings, $480 billion total health system savings).

Comparison

The ARRA provisions make an initial investment in comparative effectiveness research but do not provide ongoing funding or an advisory capacity to inform public or private health insurance policy decisions. Under the ARRA provisions, research

remains decentralized, conducted separately by the National Institutes of Health, the Agency for Healthcare Research and Quality, and the HHS secretary and evaluated by an advisory panel. The legislative language decouples the generation of information from payment policy.

Under the CBO option, comparative effectiveness research is funded entirely by the federal government, whereas the new center that would be established under the Path option receives both public and private funding for research and dissemination—an estimated $12 billion investment over 10 years. The CBO estimates rely on voluntary use of new information by patients and providers and do not assume a mechanism to translate evidence-based information into incentives for patients or providers to apply the information.

Under the Path option, research would be centralized in a new, independent entity, responsible for generating information and making recommendations for payment and cost-sharing policies. In addition, the policy would spread use of decision aids to inform patients of the risks and benefits of alternative treatment choices. Both policies would accelerate the use of comparative effectiveness information to improve the quality of care. In addition, both would reduce the delivery of care that is of little or no benefit, as well as reduce the delivery of high-cost care when lower-cost alternatives exist. The incorporation of new information into payment and cost-sharing policies accounts for a great deal of the estimated savings from this option.

Conclusion

As the health care reform debate unfolds, it will be important to keep in mind that there are a number of options for financing the substantial federal investment that is necessary to ensure that all Americans have affordable health coverage and to address health care access, quality, and cost issues. Without bold initiatives, the U.S. faces a future in which millions more Americans are denied access to needed care, and in which health care consumes an ever-growing share of the nation's income without providing adequate value in return.

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Notes

[1] A New Era of Responsibility: Renewing America's Promise (Washington, D.C.: Office of Management and Budget, Feb. 2009); access at : http://www.whitehouse.gov/omb/assets/fy2010_new_era/a_new_era_of_responsibility2.pdf.

[2] White House Office of Management and Budget, *Paying for Health Care Reform: $313 Billion in Additional Savings to Create a Deficit Neutral Plan,* June 2009. Accessed at: http://www.whitehouse.gov/MedicareFactSheetFinal/.

[3] S. Rosenbaum, L. Cartwright-Smith, T. Burke et al., *An Overview of Major Health Provisions Contained in the American Recovery and Reinvestment Act of 2009* (Washington, D.C.: The George Washington University School of Public Health and Health Services Department of Health Policy, Feb. 18, 2009); accessed at: http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/ARRA-Health-Care-Provision-Side-by-Side.cfm.

[4] The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009); *Budget Options, Volume 1: Health Care, The Congress of the United States* (Washington, D.C.: Congressional Budget Office, Dec. 2008); accessed at: http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf; *A New Era of Responsibility: Renewing America's Promise* (Washington, D.C.: Office of Management and Budget, Feb. 2009); accessed at http://www.whitehouse.gov/omb/assets/fy2010_new_era/a_new_era_of_responsibility2.pdf.