Comprehensive Health Reform Costs Less: A Comparison of Four Proposals

Staff Working Paper

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December 17, 2008

About The Lewin Group

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Executive Summary

Bold, comprehensive health reforms that assure immediate health insurance coverage for all Americans can be far less expensive than incremental reforms that cover little more than half of the uninsured. Comprehensive reforms can reduce health spending while also reducing the federal deficit by targeting those fundamental elements of the system that contribute to inefficiency and uncontrolled cost growth, such as consumer incentives and excessively complex administration. Incremental reforms that do not address these core problems will not save enough to achieve universal coverage without dramatically increasing the federal deficit.

In the 2008 presidential campaign President-elect Obama proposed to expand coverage for low- and middle-income families through a Medicaid expansion and a tax credit for the purchase of health insurance. He also includes several cost containment initiatives such as funding for Health Information Technology (HIT), creation of a "Comparative Effectiveness Institute" and improved care for those with chronic health conditions.

We estimate that if fully implemented in 2010, the Obama proposal would cover 26.6 million of the estimated 48.9 million people who will be uninsured by that time. Even with these cost savings initiatives, the program would increase the federal deficit by $1.17 trillion over the 2010 through 2019 period. Federal costs are high because these incremental cost savings initiatives would reduce health spending by only about 1.5 percent over these ten years. Also, most of these savings would be for the Medicare program with little savings for privately insured people who are at-risk of losing their insurance.

The tax credit proposal introduced by Senator McCain in the 2008 campaign was another incremental reform that would have covered about 21.1 million of the uninsured. It too included cost containment initiatives such as promoting HIT and coordinated care for the chronically ill. Yet the McCain plan would have increased the federal deficit by $2.05 trillion over ten years.

By comparison, the Healthy Americans Act (HAA) introduced by Senators Wyden and Bennett would cover nearly all of the uninsured while actually reducing the federal deficit by $343.1 billion over ten years. This is consistent with a recent Congressional Budget Office (CBO) analysis showing that the HAA would be fully funded in the first full-year of operation, with savings increasing in subsequent years. The HAA does this with a market-based approach that creates new incentives for consumers to enroll in more efficient health plans, and by creating a greatly simplified approach to administering coverage and financing.

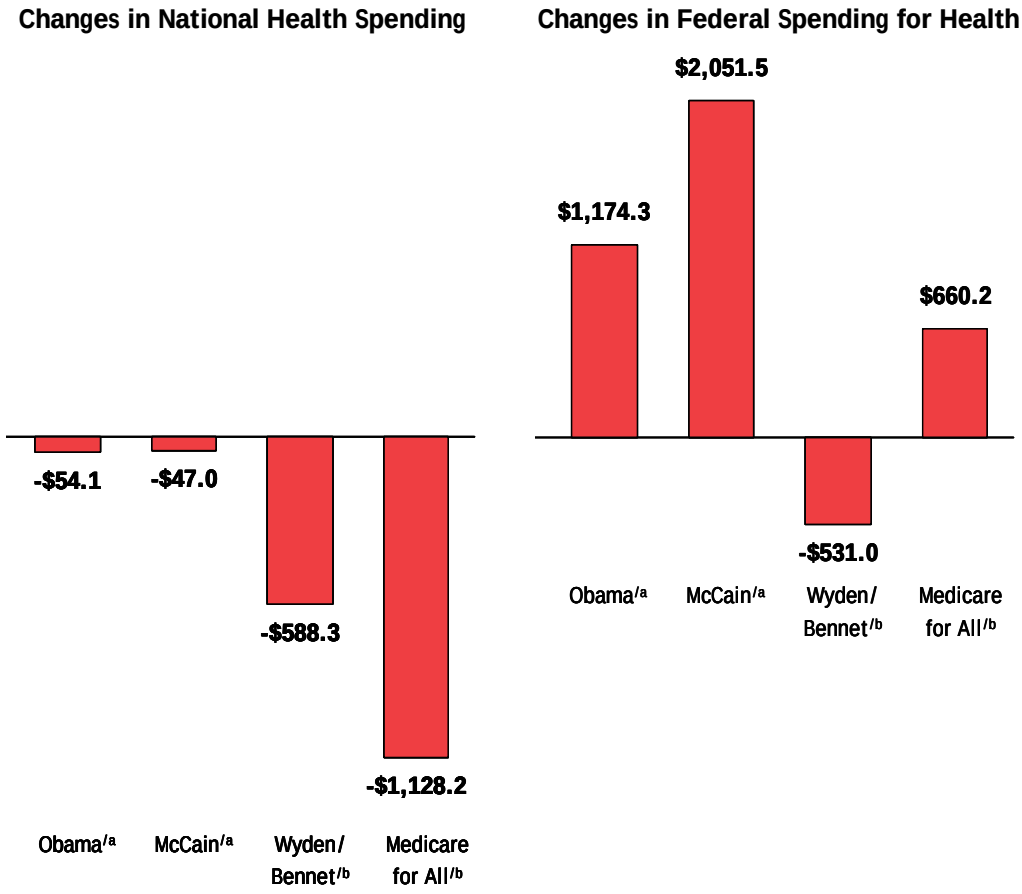
Moreover, the Obama cost savings initiatives could be implemented together with nearly any comprehensive health reform proposal. For example, if implemented together with the HAA, ten-year federal savings would increase to $531 billion (***Figure ES-1***). Overall, the HAA would reduce total national spending for health – which includes all spending by families, employers, and governments – by $588.3 billion if implemented together with Obama's cost control initiatives. Other ideas included in the plan recently introduced by Senator Baucus could be similarly included.

Other Comprehensive reforms would also cost less than incremental approaches. For example, we estimated the cost of a "Medicare-For-All" (MFA) universal coverage proposal modeled on similar bills proposed separately by representatives Stark, Conyers and Dingell. This

comprehensive health reform plan would require employers and families to pay a premium in proportion to income. The program achieves savings through greatly simplified administration and the use of price controls for health services.

If implemented together with the Obama cost control initiatives, the MFA program would increase federal health spending by about $660.2 billion. While a substantial increase in the deficit, this is only about half the $1.17 trillion increase in the federal deficit under the Obama bill, which still leaves over 20 million people uninsured. National health spending with the Obama cost controls would be reduced by about $1.13 billion under the MFA model.

Figure ES-1
Change in National Health Spending and Federal Health Spending under Selected Health Proposals: 2010 – 2019 (billions)



a/ Includes cost controls introduced by each of the Candidates.
b/ In these scenarios, we assume that the cost control initiatives introduced by President-elect Obama are implemented together with the Wyden/Bennett and Medicare-for-All proposals.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Comprehensive reforms save money by targeting the underlying flaws in the existing system that account for inefficiency and rapid cost growth. The HAA achieves this by: changing consumer incentives; using competing health plans to provide coverage options to all Americans; and adopting a streamlined approach to administering coverage and financing. The MFA program

achieves savings through a single-uniform program that dramatically reduces administrative costs and controls spending through provider price regulation.

This analysis shows that bold comprehensive health reform can cover all of the uninsured for far less than we would spend to cover far fewer of the uninsured under incremental reforms. Comprehensive reform is less costly both to the nation and the federal government. This is true whether we pursue a market-based approach such as the HAA, or a government-run model such as the MFA program.

Comprehensive Reform Costs Less: A Comparison of Four Proposals

It is widely thought that the federal government can not at this time afford to adopt bold comprehensive health reforms that extend health insurance coverage to all Americans. As a stop-gap, some policy-makers propose incremental expansions in public and private coverage together with new initiatives to control costs within the existing system. Hopefully, these cost control initiatives will slow the growth in costs enough that the federal government will someday be able to afford to provide universal health insurance coverage.

In this paper we show that bold comprehensive reforms offering immediate coverage for all Americans are actually far less expensive than incremental efforts to slowly build upon the existing system. It is possible to cover all Americans without increasing national health spending and without rationing care. Costs can be reduced for American consumers in general and the federal government in particular under broad-based universal coverage reforms.

To demonstrate this we present estimates of the cost of two comprehensive health reform plans that would change the way we pay for health care in the US while assuring coverage for all Americans. We include the "Healthy Americans Act" (HAA) developed by Senator's Wyden and Bennett that uses a market-based approach to cover all of the non-Medicare population under private health insurance plans. We also include a government-based approach that would cover all Americans under an expanded Medicare program.

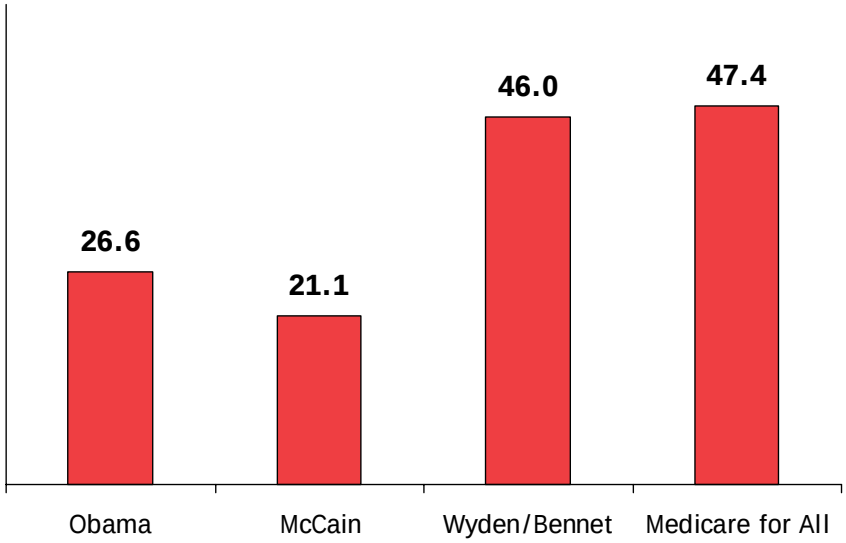
To illustrate this, we compare the cost of these universal coverage programs to the cost of the incrementally-based health reform proposals introduced by President-elect Obama and Senator McCain in the 2008 presidential election. The Obama proposal would expand Medicaid and provide a tax credit to help lower- and middle-income families purchase private health insurance. It includes several initiatives to reduce costs including improved prevention and primary care for the chronically ill. The McCain plan included tax credits for the purchase of private health insurance while emphasizing changes in tax incentives and deregulation of insurance to reduce costs.

We show that the cost of comprehensive health reform over the next decade would be hundreds of billions of dollars less than the incremental reforms proposed by Obama, and McCain. Also, we show that Federal spending under these comprehensive reform plans would be much less than under these incremental reforms. Savings under these comprehensive reform options could be further enhanced by implementing them together with the various cost containment initiatives proposed separately by President-elect Obama and Senator Baucus.

Four Models for Health Reform

The proposals introduced by Senators Obama and McCain are excellent examples of incremental health reforms that build upon the existing health insurance system. In 2010, the Obama Plan would cover about 26.6 million of the 48.9 million uninsured people that we estimate for that year. The McCain plan would cover about 21.1 million of the uninsured (***Figure 1***).

Figure 1
Reduction in the Number of Uninsured People under Selected Policy Options in 2010 (millions)[/a]



a/ We project that there will be 48.9 million uninsured people in 2010 under current law.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The Healthy Americans Act and the "Medicare for All" proposals would both cover over 46 million of the uninsured. Those who remain uninsured would include primarily undocumented immigrants and other hard to reach populations. However, both of these proposals would do so through a newly restructured health insurance system.

President Elect Obama's Reform Proposals: The Obama proposal would expand Medicaid eligibility to include all very low-income adults and would provide premium subsidies for people with low to moderate incomes. Insurers would be prohibited from denying coverage or setting insurance premiums on the basis of health status. Also, the Obama plan would provide small employers with a tax credit for the purchase of insurance and would create a federally subsidized reinsurance program to cover "catastrophic health" expenses under employer plans.

Senator Obama's plan would also create a "National Exchange" offering a selection of private health insurance options and a new national plan comparable to the coverage options offered to members of Congress and federal workers. The Obama plan would also require the use of care coordination services for the chronically ill under Medicare and other federal programs and includes several additional cost containment initiatives.

Senator McCain's Proposal: The McCain proposal would replace the current tax exclusion for health benefits provided by employers with a refundable tax credit of $2,500 for single filers and $5,000 for families with private insurance, including individually purchased non-group coverage. Insurers would be permitted to sell insurance across state lines, thus sidestepping state minimum benefit and insurance rating regulations. The plan would reduce health care costs by making people pay income tax on employer provided benefits and by permitting people to purchase coverage through states with fewer minimum benefits laws.

The Healthy Americans Act (HAA): The act provides private health insurance to all of the non-Medicare population including those now covered through Medicaid. Employers would be required to "cash-out" their health plans by converting what they now spend on worker health benefits to increased wages for their workers. Participants would then purchase coverage from a selection of private plans offered through regional "Health Help Agencies" (HHAs), similar to the exchange proposed by President-elect Obama. Workers would have the option of remaining with their employer plan but would still receive the cash-out and would have to use it to purchase the employer's plan.

All HAA participants would pay premiums through their annual income tax filings. The premium is fully subsidized for those below 100 percent of the federal poverty level (FPL), with the premium phasing-in for people living between 100 percent and 400 percent of the FPL. The current tax exemption for employer-provided health benefits is eliminated to strengthen incentives for families to seek lower cost coverage. However, a new "health premium" tax deduction is created so that these wage increases generally do not increase federal personal income tax payments. Employers would pay an amount for each worker equal to between 3 percent and 26 percent of the premium, depending on firm size and other factors.

Medicare-For-All (MFA): We specified a proposal to cover all Americans under the Medicare program similar to legislation introduced separately by Congressmen Stark, Conyers andDingell. We assume that the benefits would be similar to the Blue Cross/Blue Shield Standard option plan offered under the Federal Employees Health Benefits Program (FEHBP). Participants would pay a premium that is subsidized on a sliding scale with income through 500 percent of the FPL. Employers are required to pay 80 percent of the premium for their workers. Providers would be paid on the basis of the Medicare fee-for-service (FFS) payment levels for all participants.

Employers would have the option to offer coverage as long as the benefits and employer contribution percentage are at least what is required under the MFA program. Also, participants would have the option of enrolling in a private plan under the current Medicaid Advantage program. To assure comparability with the other proposals included in this study, we assume that there are no changes in benefits and premium amounts for people currently covered under Medicare.

Impact of Coverage Expansions on National Health Spending

The relative efficiency of alternative reform models can be gauged by the proposal's impact on national health spending. Total health spending is projected to reach $2.7 trillion in 2010 and will total more than $37.0 trillion over the 2010 through 2019 period. This includes all expenditures for health services and supplies regardless of who pays for the care. It includes spending by families, employers and governments and includes payments to health providers and the cost of insurance and program administration. ***Figure 2*** presents a summary of the impact of the four coverage expansion provisions on national health spending over the 2010 through 2019 period.[1] (We present the impact of cost control initiatives in the section that follows).

[1] These estimates assume that enrollment levels have fully matured to expected levels.

Figure 2
Impact of the Four Coverage Expansion Proposals on National Health Expenditures: 2010-2019 (billions)

	Obama	McCain	Wyden/Bennett (HAA)	Medicare for All
Utilization for Newly Insured	$475.1	$171.6	$705.3	$721.3
Change in Provider Reimbursement	$105.0	$131.8	$506.1	($411.8)
Tax Incentives and Competition	--	($162.5)	($683.5)	--
Insurer Administration	($62.7)	$87.1	($544.6)	($866.0)
Net Change	**$517.5**	**$228.0**	**($16.7)**	**($556.6)**

Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Health spending under the Obama coverage expansions would increase by $517.5 billion over these ten years. The ten-year cost of increased health services utilization for the 26.6 million newly insured people per year would be $475.1 billion. Provider reimbursement would increase by $105.0 billion. This reflects reductions in uncompensated care offset by the lower levels of provider reimbursement for people entering the new national public plan created under the proposal. Insurer administrative costs would decline by $62.7 billion due to lower levels of administrative costs under the National exchange and the National plan.

Health spending over the 2010 through 2019 period would increase by about $228.0 billion under the McCain plan. This includes increased utilization for newly insured people of $171.6 billion, all of whom would be covered under private health insurance.[2] Insurer administrative costs would increase by $87.1 billion, reflecting the higher levels of administrative costs under private insurance. Provider reimbursement would also increase by $131.8 billion due to reduced uncompensated care.

National health spending would actually be lower under the HAA and MFA proposals, even though these plans would cover over 20 million more of the uninsured than the Obama or McCain proposals. The Wyden/Bennett proposal would result in a net reduction in health spending of $16.7 billion over the ten-year period. This includes increased health services utilization of $705.3 billion and a $506.1 billion increase in provider payment levels for Medicaid beneficiaries which would now be covered under private insurance (private insurer payment levels can be up to twice what is paid by Medicaid for the same services).

These increases in spending under the HAA would be largely offset by spending reductions of $683.5 billion resulting from new incentives due to elimination of the tax exclusion for employer provided health benefits and increased competition among insurers. This is a savings of about 3.5 percent across the HAA covered population over this ten-year period. The program is designed to provide incentives for consumers to demand lower-cost health coverage, resulting in lower health care costs. These cost containment features include:

[2] Our analysis showed that due to changes in the regulation of insurer rating practices, much of the reduction in the uninsured occurred among younger cohorts where health services utilization tends to be lowest.

- All participants will have access to lower cost coverage alternatives through the HHAs (i.e., exchange), including integrated delivery systems such as HMOs and Health Savings Accounts. This differs from today's system where most workers have only one or two coverage options available to them through work;
- Employer spending for health benefits is paid as wages so that the worker faces the full cost of insurance. People retain the full amount of any savings from selecting a lower cost plan rather than sharing these savings with their employer;
- The tax exclusion for employer provided health benefits is eliminated to increase people's incentives to seek out lower cost coverage; and
- People must pay the full additional cost for selecting a higher cost health plan.

The Wyden Bennett plan reduces the cost of insurer and program administration by $556.6 billion over the 2010 through 2019 period. Much of this stems from the fact that Coverage is no longer linked to employment and there are no transitions in coverage outside of an annual open enrollment period (except if electing their employer's coverage). Thus, people are never "dropped" from coverage regardless of changes in employment, income or marital status. Administration is streamlined as follows:

- The HHAs organize regional enrollment into large blocks of business for individual insurers, thus reducing the insurer cost of administering plan selection and premium collections;
- Premiums are collected through the tax system on the basis of the family's ability to pay, which largely eliminates the cost of collecting premiums;
- No income-testing at the point of enrollment as under Medicaid;
- There are no changes in coverage due to job change or changes in family status; and
- To provide continuity for workers, large employers are required to administer annual open enrollment for their workers.

The Medicare-For-All (MFA) plan would reduce total health spending by $556.6 billion over the ten-year period. There would be an initial increase in utilization of health services of $721.3 billion for newly insured people. However, provider reimbursement would fall by $411.8 billion despite large reductions in uncompensated care. This reflects the shift of privately insured people to Medicare where provider reimbursement levels are between 20 and 30 percent lower than under private health plans.[3] This estimate also includes reduced spending for prescription drugs due to bulk purchasing.[4]

[3] This is an estimate of the net change in provider reimbursement reflecting reductions in reimbursement for people currently covered under private insurance, increases in reimbursement for people now covered under Medicaid and reduced uncompensated care. See: American Hospital Association, "Trends Affecting Hospitals and Health Systems, Trendwatch Chartbook April 2008; and "Report to Congress: Medicare Payment Policy," Medicare Payment Advisory Commission (MedPAC), March 2008.

[4] We assume savings in drug purchases of about 6 percent overall.

The MFA program would reduce insurer and public program administrative costs by $866.0 billion over the 2010 through 2019 period. Administrative costs for Medicare ($30.7 billion in 2010) are equal to about 5.8 percent of total program costs. By comparison, administrative costs comprise about 12.6 percent ($118.2 billion in 2010) of total spending for private health insurance.[5] The lower level of administration reflects that:

- There are no transitions in coverage to administer;
- Premiums are collected through the tax system in proportion to ability to pay;
- There is no income testing for the program as under Medicaid;
- Providers are paid through a uniform payment system, thus eliminating the cost to providers of complying with multiple reimbursement and utilization management rules.

Health System Savings Initiatives

Both the Obama and McCain proposals included provisions designed to reduce the growth in health spending within existing health programs, starting with Medicare. For example, both candidates proposed initiatives to improve the delivery of care for the chronically ill, who account for about 75 percent of all health spending.[6] Also, Senator Baucus recently introduced a proposal that would also emphasize improvements in preventive and primary care and new payment systems that create incentives for providers to improve quality and keep patients healthy.[7] The key cost control provisions of the Obama proposal include:

- **Institute for comparative effectiveness:** Senator Obama would "establish an institute to guide reviews and research on comparative effectiveness so that Americans and their doctors will have accurate and objective information to make the best decisions for their health and well-being." The Institute would research the relative effectiveness of alternate treatments and promulgating evidence-based guidelines. Because there is overwhelming evidence of poor adherence to existing medical guidelines, we estimate that savings from this proposal would be only about $39.9 billion, which is the savings net of Institute operations and research spending.[8]

- **Fund health information technology (HIT):** The Obama proposal would provide $10.0 billion in funding each year for five years to expand the use of HIT that reduces provider costs and facilitates improved health outcomes. Because HIT is already expected to be widely implemented under current trends, most of the expected savings will occur without government intervention. The added savings from accelerating the adoption of

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5 National Health Expenditure Projections 2007-2017, Office of the Actuary, Centers for Medicare & Medicaid Services, 7500 Security Boulevard Baltimore, MD 21244

6 Thorpe (2007), "Potential Savings Under the AdvaMed Plan Associated with Health Reforms Focusing on Chronic Care Management, Prevention and Health Information Technology" found at: http://www.advamed.org/NR/rdonlyres/03AE0ADD-3472-4F29-BC58-32EC0575AB67/0/healthreformsavingsthorpeFINAL.pdf

7 "A Call to Action: Health Reform 2009," U.S. Senator Max Baucus, Chairman, Senate Finance Committee, November 12, 2008.

8 We have estimated that savings could be dramatically larger if financial incentives were introduced to encourage physicians and patients to adhere to guidelines.

HIT would be $111.2 billion over ten years, net of the $50 billion that would be invested by the federal government.

- **Medicare overpayments:** The payment levels for Medicare advantage plans are estimated to be up to 12 percent higher than what participating beneficiaries would on average cost under the Medicare fee-for-service program. Savings to Medicare from eliminating these overpayments would be $135.3 billion.
- **Prescription drug price negotiation**: The Obama proposal would authorize the Secretary of the Department of Health and Human Services (HHS) to negotiate prescription drug prices directly with drug manufacturers for Part D of Medicare. The Congressional Budget Office estimates that this is not expected to reduce costs except for single-source drugs with no therapeutic alternative. We estimate savings would be $18 billion over 10 years.
- **Drug re-importation**: The Obama proposal provides for safe re-importation of drugs from other countries resulting in savings to both Medicare and private health insurance. Ten-year savings would be $42.6 billion. This estimate was derived from CBO analyses.
- **Disease management (DM):** The Obama proposal would require the use of DM programs in Medicare, the new National Exchange and the Federal Employees Health Benefits Program (FEHBP). However, extensive research in this area has failed to establish that DM reduces costs, although there is evidence of improved health outcomes. The strongest evidence for savings was in treatment for patients with diabetes and cardiac conditions. Based on this, we estimate potential savings of about $43.6 billion over the 10-year period.
- **Medical home**: The Obama plan supports the use of the medical home model to coordinate the care provided to patients being treated for multiple health conditions. Because the proposal does not specify how this would be implemented, we modeled it assuming that participation would be optional. Savings would be $132.9 billion over the 2010 through 2019 period.
- **Pay-for-performance:** The plan would require adoption of the pay-for-performance model under Medicare, FEHBP and plans in the new National Exchange. For illustrative purposes, we assumed that the Obama plan will expand the CMS Premier Hospital Quality Incentive Demonstration (HQID) to apply to all acute care hospitals.[9] We estimate savings of about $48.1 billion over 10 years based on this model.

These initiatives would be implemented primarily through the Medicare program, with the expectation that private payers would eventually adopt these new programs and payment systems as they are proven effective under Medicare. The implication is that expansions in coverage would be financed with savings to federal programs from these initiatives.

Total savings under the Obama plan would be $571.6 billion over the 2010 through 2019 period (***Figure 3***).[10] These include $111.2 billion in savings from expanded use of HIT, $39.3 billion in

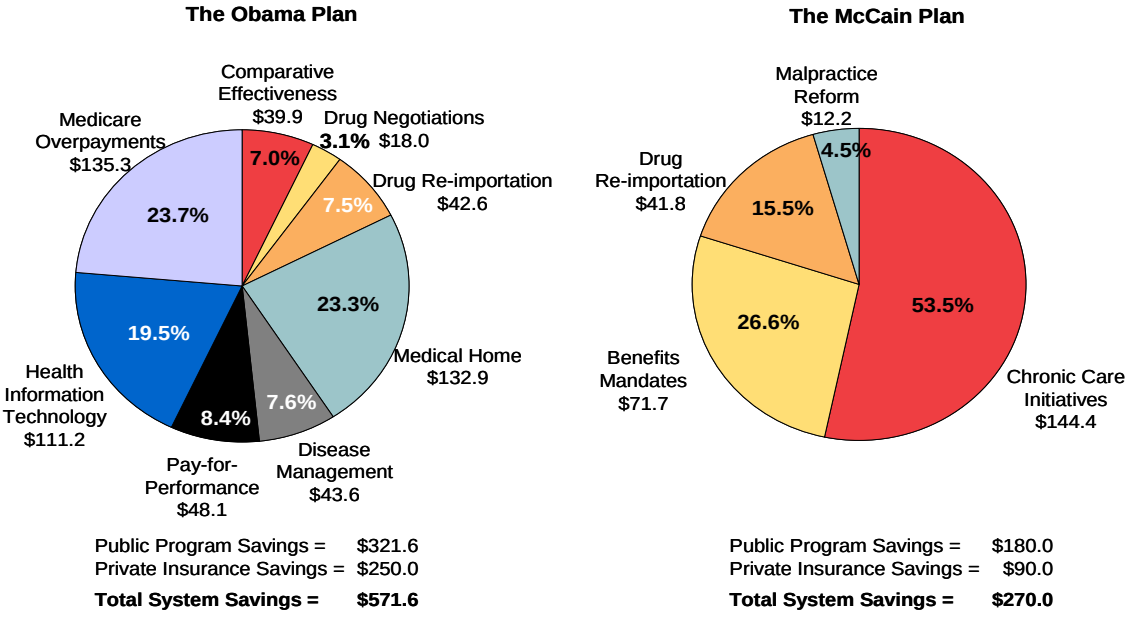
[9] Premier is a nationwide association of not-for-profit hospitals.

[10] "McCain and Obama Health Care Policies: Cost and Coverage Compared," (report by the Lewin Group), October 8, 2008

savings from the comparative effectiveness institute and about $224.6 billion in savings from disease management, the medical home model and pay-for-performance. The McCain plan would save about $270.0 billion over that decade, primarily from health initiatives for people with chronic illnesses.

Savings under the Obama plan ($571.6 billion) will be equal to only about 1.5 percent of total projected health spending for 2010 through 2019 (about $37.0 trillion). Most of these savings would accrue to Medicare and other public programs and would have little impact on costs for the non-Medicare population. For example, only about 43 percent of savings under the Obama plan would accrue to people with private insurance coverage. Thus, these plans will do little to improve the affordability of coverage for the non-aged population, which accounts for nearly all of the uninsured.

Figure 3
Reduction in National Health Spending under System Saving Provisions of the McCain and Obama Proposals (billions)



Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

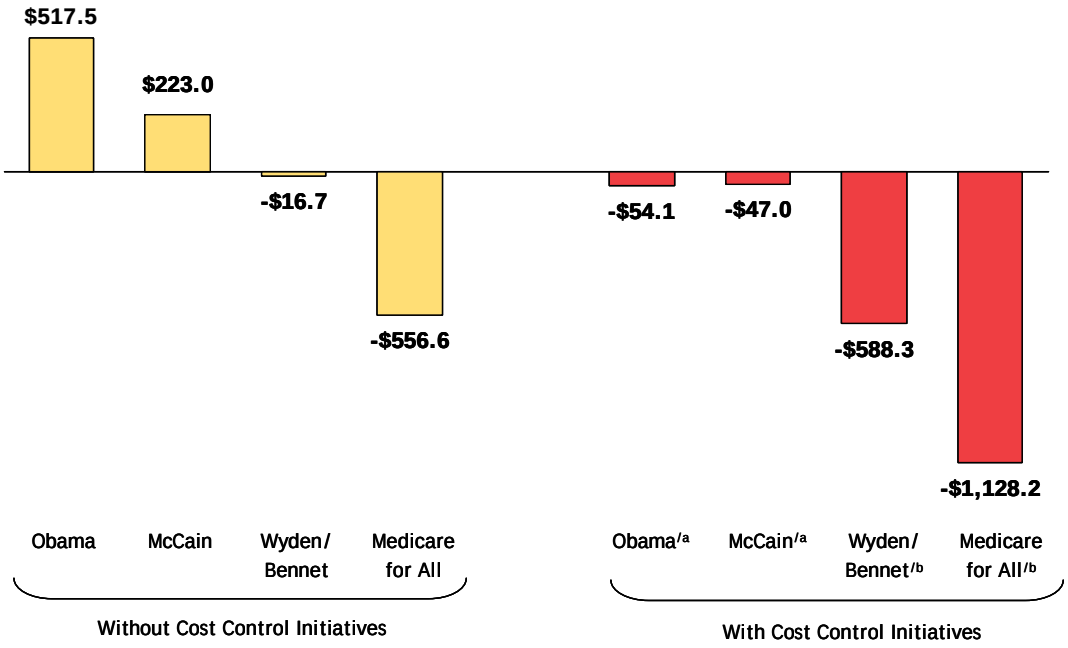
Impact of Cost Control Initiatives on National Health Spending

As discussed above, without the cost control initiatives proposed by President-elect Obama, health spending over the next decade would increase by $517.5 billion under this proposal. With these initiatives, total spending would be reduced by $571.6 billion resulting in a net reduction in national health spending of $54.1 billion over the 2010 through 2019 period (***Figure 4***). The cost control initiatives under the McCain proposal would result in a net ten-year reduction in national health spending of $47.0 billion.

The savings initiatives introduced by Presidential-elect Obama or Senator Baucus can be incorporated into any health reform proposal including the HAA and MFA plans. For example, a

clinical effectiveness institute and the HIT funding could be included in any proposal. The various proposals to improve chronic care for the Medicare population also could be implemented since the HAA and MFA proposals do not replace the existing Medicare program for the aged and disabled.

Figure 4
Net Change in National Health Spending Under Selected Health Reform: 2010-2019
(billions)



a/ Includes cost controls introduced by each of the Candidates.
b/ In these scenarios, we assume that the cost control proposals introduced by President-elect Obama are implemented together with the Wyden/Bennett and Medicare-for-All proposals.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

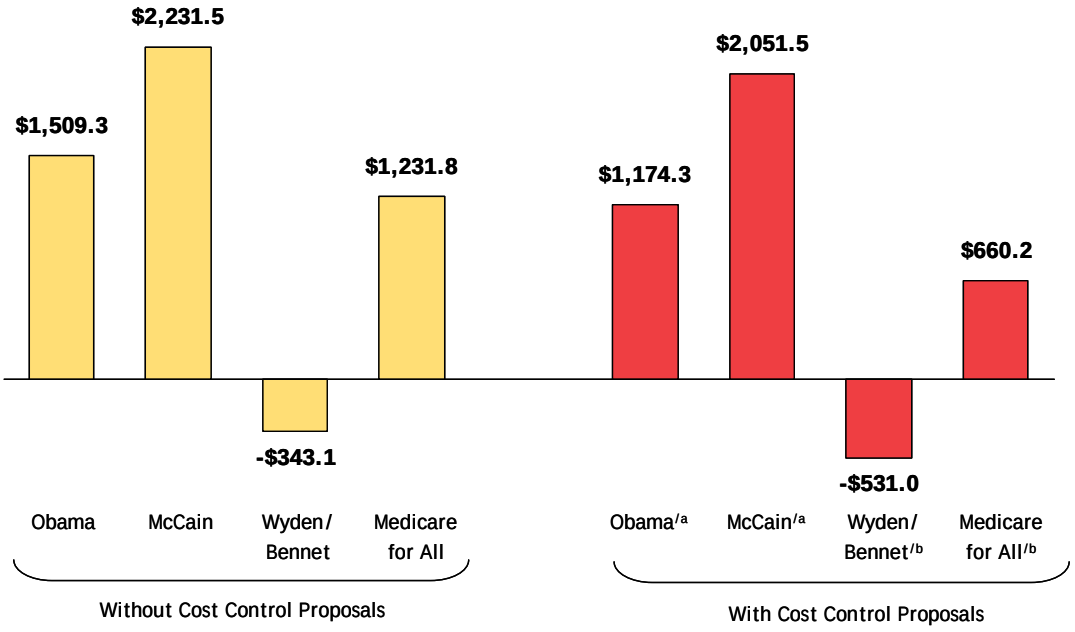
For example, if the Obama cost control initiatives are implemented together with the HAA, national health spending would be reduced by a total of about $588.3 billion over the 2010 through 2019 period. If we adopted these initiatives as part of the MFA proposal, national health spending would be reduced by about $1.13 trillion over these ten years.

These comprehensive reform plans can reduce spending while covering nearly all of the uninsured because they adopt fundamental reforms that improve the efficiency of the health care system. The HAA creates new financial incentives that enhance competition resulting in greater enrollment in efficient integrated delivery systems. The MFA controls costs with price controls for health services. Both proposals also adopt streamlined approaches for financing and administering insurance that reduce the cost of administering health coverage.

Federal Health Spending

Comprehensive health reform models also can be less costly to the Federal government than the incremental reform proposals now under consideration, even though these reforms would cover nearly all Americans. For example, the Obama proposal would increase federal spending for health by $1.17 trillion, even after accounting for proposed cost control initiatives (***Figure 5***). The McCain proposal would have cost the federal treasury $2.05 trillion due to the size of the proposed tax credit.

Figure 5
Net Federal Cost of Selected Health Reform Proposals: 2010-2019
(billions)



a/ Includes cost controls introduced by each of the Candidates.
b/ In these scenarios, we assume that the cost control initiatives introduced by President-elect Obama are implemented together with the Wyden/Bennett and Medicare-for-All proposals.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The HAA proposal would reduce federal health expenditures by $343.1 billion over the 2010 through 2019 period, even without additional cost control initiatives. This is consistent with a CBO analysis of the proposal which reported the plan would be fully funded with the financing measures included in the Act in the first full-year of program operation (i.e., the third year), with savings increasing in subsequent years.[11] We estimate that if the HAA is implemented together with the Obama cost control initiatives, ten-year federal savings would reach $531.0 billion.

[11] Letter from Congressional Budget Office Director Peter Orszag and Joint Committee on Taxation Chief of Staff Edward Kleinbard to Senators Ron Wyden and Robert Bennett, Preliminary Analysis of a Proposal for Comprehensive Health Insurance (May 1, 2008).

The premiums proposed under the MFA plan would not be sufficient to fully fund the program. The program would increase net federal spending on health by $1.23 trillion over the 2010 through 2019 period. However, if implemented together with the Obama cost containment initiatives, the increase in federal health spending would decrease to $660.2 billion. This is a bit more than half of the $1.17 trillion increase in federal spending required to implement the Obama proposal.

The Underlying Rate of Growth in Health Spending

In the analyses presented above, we assume no change in the underlying rate of growth in health spending. Our assumptions on cost growth are based upon projections provided by the Office of the Actuary of the Center for Medicare and Medicaid Services (CMS), and are identical for each scenario. This assumes no slowing of medical technology or growing consumer demand for health services (except as accounted for by changing population demographics).

In fact, in a prior study we estimated that the HAA would slow the rate of growth in health spending by up to 0.8 percentage points per year, resulting in savings in national health spending of up to $1.4 trillion over ten years.[12] This is based upon studies showing that increases in consumer price incentives increase enrollment in integrated delivery systems such as HMOs, and that the growth in health spending is reduced as the share of the market enrolled in such plans increases.[13,14,15] To be conservative, we did not include that assumption in this analysis.

We also assumed that premiums under the MFA program would be permitted to grow at the same rate that health care costs are expected to grow under current law. In fact, Congress may find it difficult to allow premiums to grow by 6.8 percent per year as projected while wage levels grow by less than 3.5 percent per year. Thus, it is possible to achieve much greater savings under the MFA program by slowing the rate of growth in provider payment levels.

Conclusions

This analysis shows that bold comprehensive health reform can cover all of the uninsured for far less than we would spend to cover even half of the uninsured under the existing health care system. Comprehensive reform is less costly both to the nation and the federal government. This is true whether we pursue a market-based approach such as the HAA, or a purely government-run model such as the MFA program.

Comprehensive reforms save money by targeting the underlying flaws in the existing system that account for inefficiency and uncontrolled cost growth. The Wyden/Bennett bill achieves this by: changing consumer incentives, providing coverage options to all through competing health plans,

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12 John Sheils, "The Cost and Coverage Impacts of the "Healthy Americans Act," Staff Working Paper, revised August 8, 2008.

13 Robinson, J.C., "HMO Market Penetration and Hospital Cost Inflation in California," *Journal of the American Medical Association*, 266 (20 November 1991): 2719-23.

14 Zwanziger and Melnick, "Costs and Price Competition in California Hospitals, 1980-90," *Health Affairs*, Vol. 13, No 4, Fall 1994.

15 Welch, W.P., "HMO Market Share and its Effect on Local Medicare Costs," HMOs and the Elderly, Health Administration Press, Ann Arbor Michigan 1994.

and adopting a streamlined approach to administering coverage and financing. The MFA program achieves savings through a single-uniform program that dramatically reduces administrative costs and controls spending through provider price regulation.

The relative merits of a market-based vs. a government-administered health insurance system are not the subject of this analysis. The point of this study is only that we can provide access to care for all Americans without increasing what the nation spends on health care and without increasing the federal deficit. Incremental expansions in coverage that build upon the existing system are perhaps the most costly and least effective of the options available to us.