

Federal Costs and Savings Associated with Senator Kerry's Health Care Plan

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This note updates a previous estimate (May 16, 2003) of Senator Kerry's health care plan. The estimates presented here differ in two respects from my earlier analysis:

1. The new estimates now include the most recent 10-year federal budget window, federal fiscal years 2005-2014. The estimates assume the plan starts during calendar year 2006.
2. The new estimates also analyze other aspects of Senator Kerry's health care plan that are designed to make health care more affordable and generate health care savings. My previous estimate did not consider these savings.

As a result, the most recent analysis presents the net impact (the total federal costs less associated savings outlined in other Kerry policy proposals) of Senator Kerry's healthcare plan. The net cost of the plan including federal savings is estimated at \$653 Billion over the ten year period. This includes \$176.6 Billion in tax cut initiatives for the purchase of health insurance by qualifying small businesses, 55-65 year olds, and workers in-between jobs as well as for new premium limitation protections; taken together, these policies reduce revenue receipts by this amount over 10 years. (Over 5 years, the plan would cost, on net, \$176.3 Billion from 2005 through 2009; and includes \$61.2 Billion in tax initiatives). When fully implemented, it would extend coverage to 27 of the 43 million uninsured, effectively covering 95 percent of all Americans.

I. Proposals to Expand Health Insurance Coverage

Senator Kerry's plan includes several proposals that would expand health insurance coverage. These include:

- Starting in CY 2006, enrolling uninsured children in families under 300% of the poverty line into Medicaid and the State-Children's Health Insurance Program (SHCHIP).
- Enrolling uninsured parents (starting in CY 2007) in families under 200% of poverty into state Medicaid programs and the SCHIP
- Starting in CY 2008, states would enroll uninsured single adults and childless couples in poverty into Medicaid

All costs associated with the expansions will be federally funded (by swapping current state Medicaid spending on children and having the states use these dollars to enroll the new populations). The federal government would assume the state share of Medicaid spending on children.¹ Over the next ten years, this would increase federal spending by \$267 Billion. States would instead use dollars instead to enroll newly eligible adults and children. In addition, states that meet aggressive federal enrollment targets (of 90-95% enrollment of eligible uninsured populations) would receive additional federal payments. These federal payments are anticipated to cost \$15 Billion over the first three years of the program.

The Kerry plan would also allow small businesses, those aged 55 to 64 and workers between jobs to enroll in new pools with the same health plans offered through the Federal Employees Health Benefits Program (FEHB). Employers would contribute 50% of the premium, and in so doing would receive a refundable 50% tax credit. They would also receive the tax credit for any contributions above the 50% threshold. Workers between jobs would receive a 75%

¹Given the nature of the state swap, federal costs of the Kerry plan associated with the Medicaid and SCHIP expansions are naturally limited. The phase-in schedule reduces further the federal costs.

subsidy for up to six months to purchase coverage through their former employer or the FEHB pool. Those aged 55 to 64 without access to employer-sponsored insurance would receive a refundable 25% tax credit to purchase coverage in the FEHB pools. Finally, the plan limits what families pay for health insurance to 6% (and up to 12% based on income) of family income.

The Kerry plan also includes a reinsurance proposal, designed to make insurance more affordable. Employers that extend coverage to all workers (and contribute on a pro-rated basis on hours worked), return the savings to their workers, and introduce disease and care management programs into the worksite would be eligible. The reinsurance pool is designed, each year, to reduce the cost of coverage by about 10 percent for employers that meet these three criteria.

The Kerry proposal also substantially expands and fully integrates care and chronic disease management programs into Medicare, Medicaid and private health plans. In addition, the plan would require private insurers in the FEHB and other federal programs to use electronic information technologies. Both proposals would generate savings in the Medicare program and among private plans as well.

Federal Costs and Savings of the Kerry Health Insurance Proposals.

Table 1 presents updated estimates of the Kerry health insurance proposals. Since last years estimate, implementation dates for the proposal have moved back one year to coincide with the new budget window. The plan is scheduled to commence in calendar year 2006. The table presents the estimated costs of the Kerry health proposal (before savings) and reflects the one year delay in the implementation of coverage for single adults, the savings generated as part of the plan, and the overall (net) federal costs.²

² The estimates assume that it takes three years to achieve the ultimate rate of Medicaid and SCHIP enrollment. For instance, single adults and childless couples become eligible in 2008 for Medicaid, and are fully (90%) enrolled by the year 2010. This is based on actual state experience in enrolling new populations into Medicaid and the SCHIP. Moreover, the enrollment lag is similar to those used in the past by the Congressional Budget Office.

Table 1. Estimated Federal Outlays, Savings and Net Federal Spending By Fiscal Year, in Billions of Dollars										
Year	2006	2007	2008	2009	2010	2011	2012	2013	2014	2005-2014
Provision										
OUTLAYS PRIOR TO SAVINGS										
Medicaid Kids	5.1	9.4	10	10.8	11.5	12.4	13.3	14.3	15.3	102.1
SCHIP Kids	3.6	6.3	6.8	7.3	7.8	8.4	9.0	9.7	10.5	69.4
Parents	0	6.9	12.0	15.2	16.4	17.6	18.8	20.2	21.6	128.7
Other Adults	0	0	0	5.0	10.1	14.0	16.6	17.8	19.0	82.5
Federal Match ³	9.8	11.0	14.7	15.1	15.6	16.5	17.0	17.5	18.2	135.3
Premium limitation Protection	1.9	3.6	4.2	4.7	5.1	5.5	6.0	6.5	6.9	44.4
FEHB Pools (net)										
Small Business	4.3	6.1	6.5	7	7.6	8.1	8.5	9.1	9.7	66.9
Individuals	3.1	5.6	6.6	7.6	7.5	8.1	8.6	9.1	9.6	65.8
Reinsurance Pool (net)	5.7	9.8	24.9	29.8	32.1	34.4	37.0	39.8	43.2	256.7
SAVINGS										
Disease Mgt	-6	8.3	-10.4	-12.6	-13.5	-14.6	-15.5	-17.0	-18.6	-116.5
Care and Caid DSH coverage adjustment	-6.7	-7.9	-9.2	-9.5	-10.0	-10.4	-10.9	-11.4	-11.8	-88.0
FEHB Pool IT Savings	-1.4	-1.5	-1.7	-1.9	-2.0	-2.2	-2.4	-2.6	-2.9	-18.6
Medicaid Admin IT Savings	-2.5	-2.7	-3.0	-3.3	-3.8	-3.9	-4.2	-4.5	-4.8	-32.7
Private Plan IT Savings	-2.2	-2.4	-2.6	-2.8	-3.1	-3.4	-3.7	-4.0	-4.4	-28.6
Retain M+C Payments at pre- HR 1 levels	-0.4	-1.7	-1.7	-1.7	-1.8	-1.9	-1.6	-1.8	-1.8	-14.4

Federal Costs of Kerry Health Care Plan										
	14.3	34.2	57.1	70.7	79.5	88.6	96.5	102.6	109.6	653.1

³ Federal costs associated with the Medicaid and SCHIP expansions include the federal government assuming current state spending for Medicaid children (\$267 Billion over the next ten years). These costs are shown in both the federal match line and the newly insured totals. Federal spending also includes the federal share of paying for the newly insured populations (single adults, parents and higher income children). Given how the plan is phased in over time, the federal share of insuring these new populations is \$251 Billion. In total, federal costs associated with these provisions are \$518 Billion over the ten years.

Over the ten-year window, the estimated costs of the plan—after netting out the savings (discussed below)—are approximately \$653 Billion. The plan is projected to secure coverage for nearly 27 million currently uninsured Americans, make insurance more affordable for tens of millions more, and result in a national coverage rate of approximately 95 percent of all Americans when fully implemented.⁴

Savings

Several aspects of the Kerry health plan would also generate health care savings accruing to the federal government. **The savings estimated presented below are all associated with specific policies or other enforceable mechanisms that are likely to produce scoreable savings.** For instance, clear changes in policy, such as eliminating the additional payments to Medicare Advantage plans passed as part of the Medicare Modernization Act provide unambiguous and scoreable savings. Other programs that provide capped payments at rates below baseline payment levels (such as the disease management initiatives) also provide an enforceable approach for achieving scoreable savings. Overall, the savings presented are very modest. Savings in the cost of private insurance are assumed at less than one half of one percent. Savings in the Medicare program are assumed to be approximately a 2.5% reduction in spending. Both sets of savings are small. The potential savings associated with the Kerry plan are also presented in Table 1.

⁴The estimates also assume that some persons with private insurance would drop coverage and enroll in the program. Several studies based on actual state experience with expanding coverage similar to the Kerry plan have examined the extent of any crowd-out. The results show a very small amount of crowd out. In general, the percent of privately insured enrolled is about 20 to 30% of the take up rate for the uninsured.

Notes:

Disease Management

The Kerry plan envisions the expansion of disease and care management in the Medicare (and other) health programs beyond anything contemplated under current law. The two diseases with the most immediate promise for health care savings—heart disease (congestive heart failure, chronic obstructive pulmonary disease (COPD)) and diabetes account for approximately 30% of Medicare spending.⁵ A recent compilation of studies from America's Health Insurance Plans estimated savings from disease management of 6 to 33 percent.⁶ The higher estimates were associated with heart disease, particularly congestive heart failure (CHF). For CHF, studies have shown a reduction in hospital days of 33 to 50%. A recent national study of diabetes disease management programs in ten major cities found a 25% reduction in health care spending.⁷

For the purposes of this analysis, I have very conservatively assumed for heart disease and diabetes that a savings of 10% could be achieved (for instance directly by setting rates at 90% of the risk adjusted costs for fee-for-service Medicare). Unlike the recently passed Medicare Modernization Act which included disease management demonstrations (which has no enforceable means for generating savings and will only enroll 300,000 persons at most) , this provision has an enforceable mechanism to create Medicare savings relative to the baseline. Since plans are paid at 90% of a risk-adjusted fee-for-service rate, the savings would be approximately 10% per enrollee for those enrolled in the diabetes and heart disease care management programs. The savings could be higher if patients enroll in the disease management programs from Medicare Advantage plans. Medicare Advantage plans are paid at rates significantly above (nearly 10%) fee-for-service rates. In this situation, the per capita savings would be

⁵ Regression analysis using the 2000 Medical Expenditure Panel Survey data estimating disease attributable spending. This approach is conceptually similar to those used by the CDC and others to estimate smoking attributable health care spending.

⁶ AAHP/HIAA, The Cost Savings of Disease Management Programs: Report on a Study of Health Plans, November 2003. The study reports results from 10 health plans operating 25 different disease management programs.

⁷ V. Villagra and T. Ahmed, "Effectiveness of a Disease Management Program for Patients with Diabetes", Health Affairs 23, no. 4 (2004):255-266.

even larger. Participation in well-designed administered chronic care initiatives is assumed to rise from 50% to 80% over the ten-year period.

Information Technology Savings⁸

The estimate includes a very conservative estimate that the move toward full electronic billing of claims will only reduce private insurance premiums by 0.5%. This reduction is much smaller than many industry analysts believe. Today, approximately 40 percent of physician claims are filed electronically and overall about 60-70% of all claims are electronically filed. Average cost to process a typical paper claim (includes encounter capture and adjudication) is about \$5 to \$6 (some have estimated these costs can be as high as \$20 per claim). However, significant savings can occur with an electronic claim that automatically adjudicates billing, plan design and eligibility information. Electronic, auto-adjudication of claims can cost as little as 50 cents per claim. Assuming that all claims among those in the FEHB pools are electronically filed and auto-adjudicated could generate a reduction in costs of around \$4 to \$5 per claim.⁹ The average number of claims for those under age 65 is about 15 per year and for

⁸ These savings would not normally be shown (by CBO) separately like I have provided in the table. Rather the information technology savings would result in a small reduction in the premiums in the FEHB pools (less than 1 percent reduction). The federal subsidies applied to these premiums would also be lower (due to the 1 percent reduction in premium traced to the information technology savings in plan administration) and those are the savings displayed in the table.

⁹ Information Week, "Retooling HIP Health Plan of New York", September 23, 2002. HIP health plans show similar savings on premiums as they have moved to electronic claims. They report a single year savings of \$12 million as they moved toward electronic billing and electronic IT. Other health plans and physician practices have also observed much larger reductions in premiums and costs than estimated here. Intermountain health care, for instance, report much larger savings as they moved toward a higher share of electronic bills, John Morrissey, "E-claims trim costs, aid growth" Modern Healthcare, October 2000. Other examples (and there are many) also include Aetna Health Care (http://media.corporate-ir.net/media_files/nys/aet/reports/2Q03preparedremarks.pdf). Aetna achieved much larger savings than assumed here by increasing their share of auto-adjudicated claims from 70% to 80% in one year. The Kerry plan calls for 100% electronically filed and adjudicated claims. Aetna reduced their medical cost trends by 1% point in one year using this, and other, interventions.

the Medicare population is approximately 35 per year. Estimated savings are based on processing an additional 30 to 40 percent of claims per person at a savings of around \$5 per claim (the average cost—a mix of electronic auto-adjudicated and paper claims-- per claim then is about \$2.50). This calculation is completed separately for those newly enrolled in the FEHB pools, (federal share of) Medicaid and those with private insurance separately. With respect to private insurance savings, I calculate the reduction in premiums paid by employers (about 60 percent of total premium) and assume that 60% of these savings flow back to workers in the form of higher taxable wages. These higher wages result in additional income and payroll tax receipts that form the basis of the estimate for private plan IT savings.

Coverage Expansion DSH Adjustment

This is a straightforward scoreable saving in lower Medicare and Medicaid disproportionate share spending. The Kerry plan would extend health insurance to nearly two-thirds of the uninsured, including most of those under 200% of poverty. As a result, the dollar volume of bad debt and charity care by hospitals will fall. As a consequence, approximately 50% of uncompensated care burdens will be eliminated. The estimate assumes that 50% of Medicare and Medicaid DSH payments, however, will be retained and continue to be allocated to health care providers under the Kerry plan.

Payment Rates to Medicare Advantage Plans

The Kerry plan would eliminate the Medicare managed care "stabilization" fund that substantially overpays private plans in the Medicare system. As a result, this is a clear scoreable saving. The elimination of this provision of HR 1, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, would save approximately \$14.4 billion over the ten year window.

