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Sustainable Health Care Financing Plan

At present, much medical treatment for the uninsured is effectively financed by a "hidden tax" – hospitals pay for it largely with money they make from treating patients with private insurance, ultimately paid for by higher premiums charged on their behalf. There is wide support for establishing a program to subsidize, on a sliding scale, premiums for low income individuals and families so as to try to achieve universal coverage. If enacted, however, the question is how to pay for these subsidies without leaving a funding gap that would force government-imposed rationing of life-saving medical treatment.

A **"set aside"** would work like this, stated simply: experts would annually estimate the amount of money needed to pay for the subsidies required for the following calendar year, and based on the projected total amount of health insurance premiums expected to be paid in that year. Under Alternative A, , would announce the **percentage** that would need to be set aside to produce the funds for the subsidies. (This percentage would vary each year depending on conditions, hence the name "set aside.") The actual "setting aside" would be done by insurance companies.[1] As discussed within, there are at least three different methods by which the set-aside could be managed.

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It deserves emphasis that the “set aside” would replace the existing private-sector cost-shifting, meaning that there would be little net effect on premiums. Essentially, it would facilitate moving cost-shifting from the level of the provider to the level of the insurer.

1. The Sliding-Scale Subsidies That Will Enable All to Obtain Health Insurance Must Have an Adequate and Stable Source of Funding

A key objective of achieving universal health care coverage is to move from the sort of episodic, disconnected treatments provided the uninsured, typically in hospital emergency rooms, to the sort of coordinated, integrated care, including preventive care, that depends on being insured.

The proposal as a whole, therefore, is dependent on an ongoing, reliable, and adequate source of funding for the requisite subsidies.

2. Reliance on Cost Savings to Finance Subsidies Does Not Solve the Immediate Problem.

Various methods have been put forth to contain increases in health care costs, and advocates hope to “recapture” some or all of the savings expected to use to finance subsidizing the insurance premiums for those with low income in order to achieve universal insurance coverage. However, subsidies must begin promptly to be effective; they cannot wait until savings begin to be realized from methods to save costs – nor can they uncertainly vary from year to year depending upon the

particular savings that may be calculated as being achieved. CBO has been reticent to "score" proposed efficiency gains as adequate to cover the costs of health care reform.

The Maine Dirigo savings offset payment program, enacted in 2003, has been suggested as a model for a method of recapturing reductions in health care costs generated by health care reform.[2] However, the actual amount of savings under it has repeatedly fallen below projections. In 2006 the Dirigo Health Agency estimated $100 million in savings; the insurance superintendent ultimately certified only $34.3 million.[3] In 2007 the Agency estimated $78.1 in savings, but the insurance superintendent ultimately certified only $32.8 million.[4] Consequently, although the savings offset payments were originally intended to fund the Dirigo Health project insurance subsidies, a 2007 Blue Ribbon Commission was forced to recommend supplemental General Fund revenues to help finance them, to be generated by a variety of new taxes.[5]

3. Attempts to Fund Premium Subsidies From General Tax Funds Would Be Frustrated By An *Inherent* Gap Between Tax Revenues and Health Care Costs

Most tax revenues come from income and payroll or sales taxes. These tend to rise (and fall) with the rate of growth of the general economy. But health care costs consistently *outpace* the general economy.

Over time, general fund revenues, which increase at the rate of the general economy, will lag behind the funds needed for subsidies for health care premiums, which will grow at a higher rate,

creating an ever larger gap. In the words of Columbia University health care economist Sherry Glied, “With health costs growing faster than the economy as a whole, broad-based taxes will not raise the stream of revenue needed to assure that care for the poor keeps pace . . . .”[6] This gap has to be addressed in one of three ways – by increasing the percentage of the budget devoted to health care, diminishing what can be provided to other priorities; by increasing taxes; or by failing to meet the promised goal with regard to subsidies.

Consider what continues to happen with Medicaid. To meet budget constraints reimbursement rates for Medicaid have been kept significantly below the comparable rates for privately insured patients, resulting in “undercompensated” care. One consequence has been a reluctance on the part of providers to treat Medicaid patients, but another has been an increasing reliance on private sector cost-shifting. In effect, privately-insured patients have been charged more, and part of the money paid by insurers on their behalf (and reflected in the premiums paid for their health insurance) has gone to cross-subsidize the cost of treating Medicaid patients (just as another portion has gone to cross-subsidize the still-greater cost of treating uninsured patients – “uncompensated” care).

4. A “Set Aside” Provides a Sustainable, Reliable Funding Source for Premium Subsidies Because It Draws a Percentage of Private Spending on Health Care and Thus Keeps Pace With Health Care Costs

The “set aside” method of financing premium subsidies is directly tied to the level of health care spending in the private sector. It meets the need for each year’s subsidy payments because its

percentage is calculated to do so (annually variable), and it is feasible for it to do so because the base to which this percentage is applied is health care spending itself. It therefore fully reflects both successes and failures in efforts to constrain increases in health care costs.

Unlike either an effort to recapture savings from efforts to reduce health care costs or an attempt to rely on general funds that draw from broad-based taxes, a “set aside” relates directly to the contemporary level of health care spending. The revenue it raises increases in direct proportion to increases in health care costs, just as the subsidies it finances must do. This “model ... can provide a long-term basis for funding health care equity. It takes the growing level of private health consumption and redirects part of it to fund health care for the poor. It is a revenue source that will grow along with the need for the revenue. ... It generates a level of health care spending that ... the government can afford–today and twenty years from now.”(Glied)[7]

5. A “Set Aside” Largely Frees the Government’s General Budget From Being Held Hostage to Health Care Costs

Suppose that a “set aside” is used to finance the new sliding-scale premium subsidy program for those currently uninsured.

Further suppose that funding for Medicaid is handled as follows: in future years, the amount of money now budgeted for Medicaid, in current nominal dollars, continues to be paid out of general fund revenues toward Medicaid (i.e., a “maintenance of effort” requirement applies both to state and

to federal matching funds), but henceforth the general fund amount is never increased. Instead, the "set aside" is used immediately to bring the level of Medicaid funding up to a reimbursement level equivalent to that of standard private insurance, and in future years the "set aside" is also used to cover increases in health care costs for Medicaid (just as it is used to cover increases in subsidy amounts for the hitherto uninsured necessitated by rises in premiums for basic insurance).

[The rationale for including Medicaid is that the difference between standard insurance reimbursements and Medicaid reimbursements is now roughly being paid for by private sector cost-shifting through payments for medical care on behalf of the privately insured, so that the tradeoff for providers is on the one hand to receive standard instead of substandard reimbursement through Medicaid and on the other hand to have a "set aside" reduce, directly or indirectly, what would otherwise be an overpayment for privately insured patients to be used for (no longer necessary) private sector cost-shifting.]

A similar procedure could be followed for Medicare, the federal government program paying for health care for older people.

This would mean that all but a fixed (and, in inflation-adjusted terms, steadily declining) portion of the general fund's responsibility for health care costs would be removed from the budget. Basic financial responsibility for covering the health care costs of those otherwise unable to afford adequate health insurance would be shifted to a self-sustaining and self-adjusting financing mechanism. The focus of the government budgeting process could move to balancing other priorities in the future.

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6. A "Set Aside", Coupled With Subsidized Premiums, Could Free Providers From Uncompensated Care and From Undercompensated Care

At present, hospital emergency rooms must largely rely on private sector cost-shifting – money they make from privately-insured patients – to cover the costs of caring for those uninsured patients who lack the assets to pay for their own treatment. Doctors, hospitals, and other health care providers must also rely on private sector cost-shifting to supplement the low level of reimbursement they receive from the government to treat Medicaid patients.

There are two important problems with reliance on this private sector cost-shifting. First, it is not precisely and fairly targeted. That is, different hospitals, doctors, and other providers treat varying proportions of the privately insured, the uninsured, and those covered by Medicaid among their patients, so that the cost-shifting from private insurance is not evenly spread; some providers with a higher proportion of the uninsured or Medicaid patients wind up on the short end of the stick, while others with higher proportions of privately insured patients do relatively well.

Second, so far as the uninsured are concerned, they tend to come in for treatment when more seriously ill, so that some ailments are treated less successfully and more expensively than if they had been caught earlier. Because of EMTALA, the indigent uninsured tend to overuse hospital emergency rooms, rather than primary care providers, which is an inappropriate and inefficient use of resources. They tend to fail to get preventative care, such as screening and vaccinations, which is particularly harmful in the context of the management of chronic diseases like diabetes.

Coupling premium subsidies for the uninsured and those on Medicaid so that everyone is covered by insurance that reimburses providers at standard rates with a “set aside” to pay for this represents a tradeoff for health care providers. Essentially, it moves cost-shifting from the level of the provider to the level of the insurer. The “set aside” effectively lowers the standard reimbursement rates that providers have been receiving from private insurance on the understanding that these rates will no longer be cross-subsidizing care for the uninsured or those on Medicaid because providers will henceforth be receiving standard reimbursement rates for those patients.

For the tradeoff to work properly, the “set aside” will need to be calculated so as also to finance a fund to provide reimbursement, at appropriately estimated standard insurance rates, for any residual group of uninsured individuals who might need to be treated, such as foreign travelers.

7. From the Standpoint of Employers and Consumers, Replacing the “Hidden Tax” of Private-Sector Cost-Shifting With a Transparent “Set Aside”, And Moving Cost-Shifting From the Level of Providers to That of Insurers, Fosters a More Rational System With Greater Cost-Benefit Accountability That Can Better Constrain Health Care Costs

Why should those who pay insurance premiums support a “set aside”?

A) The “set aside” is *not* a new payment that will boost premiums. It is a way of rendering transparent, and making more rational, controlled use of, the reality that health insurance premiums now pay a “hidden tax” of private-sector cost-shifting: health care providers must charge higher

prices to the privately insured to subsidize the below-cost reimbursement rates they receive for those on Medicaid and Medicare (undercompensated care) and the lack of any reimbursement for many of the uninsured hospitals must treat in their emergency rooms under federal law, regardless of ability to pay.

B) The objective of using subsidies to achieve universal health insurance coverage is intended to achieve better coordinated care by changing the pattern of resort to episodic treatment in emergency rooms by many of the uninsured through signing them up for insurance. In the long run, this more rational approach to health care should reduce what would otherwise be spent on the hitherto uninsured, meaning that what would be collected on their behalf through the "set aside" will be less that what would be spent on their behalf through private-sector cost-shifting– translating into lower premiums.

C) How much of current private-sector health insurance premiums in fact goes to supplement Medicaid and Medicare and pay for care for the uninsured, rather than the beneficiaries they nominally cover, is now "hidden." By contrast, a "set aside" would be transparent, and therefore accountable. Only with known data can appropriate cost-benefit judgments accurately be made.[8]

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8. Methods of Implementing Set Aside

There are at least three alternative possible methodologies for implementing a set aside method of financing subsidies for premiums for insurance for the uninsured, and for bringing other government program reimbursement rate commensurate with the level for private insurance.

Percentage of Gross Revenues for Insurance. The percentage annually determined necessary for the following year could be assessed as percentage of the gross revenues (i.e., predominately premiums) of insurers (including self-insured entities). Competitive pressures would lead the insurers to offset this amount primarily through re-negotiating reimbursement rates with providers. It is important to recall that providers would no longer be forced to offer uncompensated and undercompensated care for which they had needed the present level of reimbursement rates in private insurance to achieve the requisite private-sector cost-shifting. That is why it is realistic to expect that the assessment would tend to result in lower reimbursement rates rather than higher premiums.

Percentage of Claims Paid. Another alternative would be to apply the percentage as a "withhold" from claims paid. If the rate were 10%, for example, upon receiving a claim for, under agreed reimbursement rates $1000, the insurer would pay the provider $900 and withhold $100 toward the cost of the subsides. Again, the tradeoff for providers would be that they would no longer need a private insurance overpayment to cover private sector cost-shifting for uncompensated and undercompensated care.

In a number of states, motor vehicle insurers, as a condition of doing business, are required to accept their proportionate share of high-risk insureds at premiums that do not fully cover the cost of insuring those in the high-risk pool. In a similar manner, both insurance companies and self-insured

entities could be required to provide basic insurance at discounted rates (or, in the case of those with the lowest incomes, for free) to those certified as eligible on the basis of indigency, probably in proportion to their market share. The cost of assuming this obligation would be offset by negotiating adjustments in provider reimbursement rates, just as under the first alternative.

ENDNOTES

[1]. Or other third-party payers, such as third-party administrators for self-insured entities.

[2]. Legislative Commission Report, p. 40 [Rec. 6.1].

[3]. AP, "Dirigo Health Board Calculates Savings," July 3, 2007.

[4]. AP, "Insurance commissioner pegs Dirigo savings at $32.8 million", Sept. 17, 2007.

[5]. Report of the Blue Ribbon Commission on Dirigo Health (Jan. 2007), pp. 4-5.

[6]. Sherry Glied, *Chronic Condition: Why Health Reform Fails* (1997), p 231.

[7]. *Id.* It should be noted that Professor Glied has not proposed nor endorsed the specific "set aside" method. The quotation relates more generally to her advocacy of a tax on the cost of health care to fund subsidies for insurance premiums for those who could not otherwise afford them.

[8]. It is critically important to understand that in any given year the "set aside" percentage will be a function, within the constraints of the accuracy of actuarial and economic estimates, of the basic benefit package and of the sliding-scale premium subsidy levels that have been adopted. Any adjustments that are considered necessary should therefore be made to one or both of these elements. (For example, if the "set aside" percentage comes to be considered unsustainably high, the basic benefit package could be adjusted, the eligibility level for premium subsidies could be lowered, the percentages for subsidies at various income levels could be lowered, or the like.)

What must emphatically be avoided is any effort simply to cap or otherwise limit the "set aside" percentage. To do so, instead of changing the subsidies themselves, would result in a shortfall in the subsidy program. Worse still would be to introduce limits on reimbursements from the basic benefit packages in an effort to make them "affordable;" this would simply result in bringing back the private-sector cost-shifting the "set aside" is designed to replace.