Ideas for Financing Health Reform: Revenue Measures that Also Reduce Health Spending

Statement for the Senate Committee on Finance

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About The Lewin Group

The Lewin Group is a health care and human services policy research and management consulting firm. We have over 25 years of experience in estimating the impact of major health reform proposals. The Lewin Group is committed to providing independent, objective and non-partisan analyses of policy options. In keeping with our tradition of objectivity, The Lewin Group is not an advocate for or against any legislation. The Lewin Group is part of Ingenix, Inc., which is a wholly owned subsidiary of the UnitedHealth Group. To assure the independence of its work, The Lewin Group has editorial control over all of its work products.

Ideas for Financing Health Reform: Revenue Measures that Also Reduce Health Spending

Thank you for this opportunity to address the committee on approaches to funding health reform. I am a Vice-president with The Lewin Group with 25 years experience in studying and analyzing proposals to reform health care and extend health insurance to the uninsured. We are committed to providing independent, objective and non-partisan analyses of policy proposals. We do not advocate for or against legislative proposals.

Health reform can be funded with new revenues and savings to existing federal programs. In this analysis we examine two tax-based options that would both raise revenues and reduce health spending. These include placing limits on the tax exclusion for employer health benefits and a large increase in the tax on tobacco products. We also discuss potential savings to existing federal safety-net programs under expansions in coverage that could be redirected to help pay for health reform.

We estimate that these three proposals would raise about $1.25 trillion in revenues and savings to federal programs over the 2010 through 2019 period. This is roughly equal the amount of funding required to pay for the health reform program proposed by President Obama in the 2008 campaign ($1.17 trillion).[1] These provisions would also reduce national health spending by about $461.0 billion over this period.

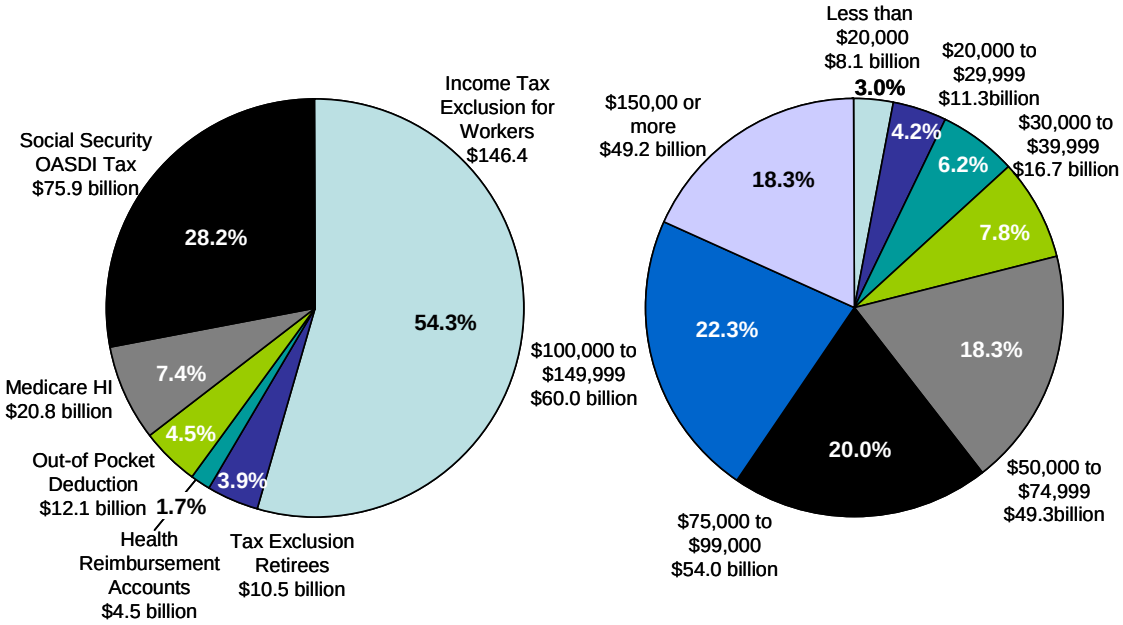
A. Changes in the Tax Exclusion for Employer-Sponsored Insurance (ESI)

Changes in the tax exclusion for employer-sponsored Insurance (ESI) would provide new revenues for reform while reducing health spending. Under current law, the cost of ESI is exempt from taxation as income to the individual for purposes of both the income tax and payroll taxes for Social Security and Medicare. For workers in Section 125 plans, the employee contribution is also tax exempt, and many workers have a tax exempt flexible spending account for payment of uncovered health expenditures.

These tax breaks will represent a loss of federal tax revenues of about $297.4 billion in 2010 ***(Figure 1)***. This includes $173.5 billion in personal income taxes and $100.1 billion in Social security and Medicare payroll tax payments. About 40.5 percent of all tax expenditures will go to families with incomes of $100,000 or more, while only about 2.3 percent would go to families with incomes below $20,000.

[1] "McCain and Obama Health Care Policies: Cost and Coverage Compared," The Lewin Group, October 8, 2009

Figure 1
Projected Health Benefits Tax Exclusion for 2010



Total Federal Tax Expenditures = $269.4

Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM)

For illustrative purposes, we estimated the impact of capping the amount of the exemption and phasing it out for high-income individuals. We also assume that the tax exempt flexible spending accounts for uncovered health expenses are eliminated. These changes include:

- **Cap the Tax Exclusion for Employer-Provided Health Insurance**: We assume that the tax exemption for employer provided benefits is capped at the average cost of employer benefits projected for 2010. The cap is $4,906 for individuals and $13,036 for families. These caps are indexed annually in proportion to the consumer price index (CPI).
- **Phase-out of Employer Benefits Tax Exclusion**: We assume that the employer health benefits tax exclusion is phased-out for taxpayers with between $250,000 and $500,000 in income and that there is no exclusion for people with over $500,000 in income. These income thresholds are indexed annually to the CPI.
- **Eliminate Flexible Spending Accounts (FSAs) for Uncovered Health Expenses:** This measure eliminates uncovered health expenditure reimbursement accounts under Section 125 FSAs (i.e., "cafeteria" plans).

These changes would provide $757.7 billion to finance health reform over the 2010 through 2019 period. The cap on the tax exclusion would raise $583.5 billion in revenues over ten years. The phase-out of the exemption for those with incomes over $250,000 would raise $114.4 billion. Eliminating the tax exempt FSA for uncovered health expenses raises about $59.8 billion.[2]

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[2] An important aspect of this proposal is that the premium cap amounts are indexed annually to the Consumer Price Index (CPI) which is expected to be about 2.8 percent per year, even though health care costs are expected to

These changes in tax policy would effectively increase the cost of health insurance to the individual, thus encouraging people to enroll in less expensive health plans such as HMOs or HSAs. We modeled the number of people shifting to lower cost plans based upon studies of how changes in the price of coverage affect consumer choice of health plans.[3] We then estimate savings resulting from the shift to lower cost plans.[4,5] Using these assumptions, we estimate a reduction in health spending for those shifting to lower cost plans of about $278.7 billion over the 2010 through 2019 period (***Figure 2***). Nearly all of these savings would apply to the privately insured population.

Figure 2
Changes in National Health Spending due to Limits on the Tax Exclusion for Employer Provided Health Benefits (billions)

Year	Changes in Revenues from Limits on the Tax Exclusion for Employer Health Benefits				Changes in Health Spending Due to Changes in Tax Incentives
	Cap on Exclusion for Employer Health Benefits	Phase-out of Exclusion for Incomes over $250,000	Eliminate Flexible Spending Accounts for Uncovered Health Care	Total Changes in Tax Revenues	
2010	$26.0	$5.2	$4.5	$35.7	-$11.4
2011	$30.4	$5.9	$4.8	$41.1	-$13.4
2012	$35.6	$7.0	$5.1	$47.7	-$15.7
2013	$41.7	$8.2	$5.4	$55.3	-$18.3
2014	$48.8	$9.6	$5.7	$64.1	-$21.4
2015	$57.1	$11.2	$5.8	$74.1	-$25.1
2016	$66.9	$13.1	$5.8	$85.7	-$29.4
2017	$78.2	$15.3	$5.9	$99.4	-$34.4
2018	$91.6	$17.9	$5.9	$115.4	-$40.2
2019	$107.2	$21.0	$5.9	$134.1	-$69.5
2010-2014	**$182.5**	**$35.9**	**$27.2**	**$245.6**	**-$80.2**
2010-2019	**$583.5**	**$114.4**	**$59.8**	**$757.1**	**-$278.7**

Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM)

grow at between 6 percent and 7 percent per year over this period. This means that over time, the proportion of ESI benefits that is taxable increases over time. As a consequence, the revenues raised through the tax cap grow by up to 17 percent per year.

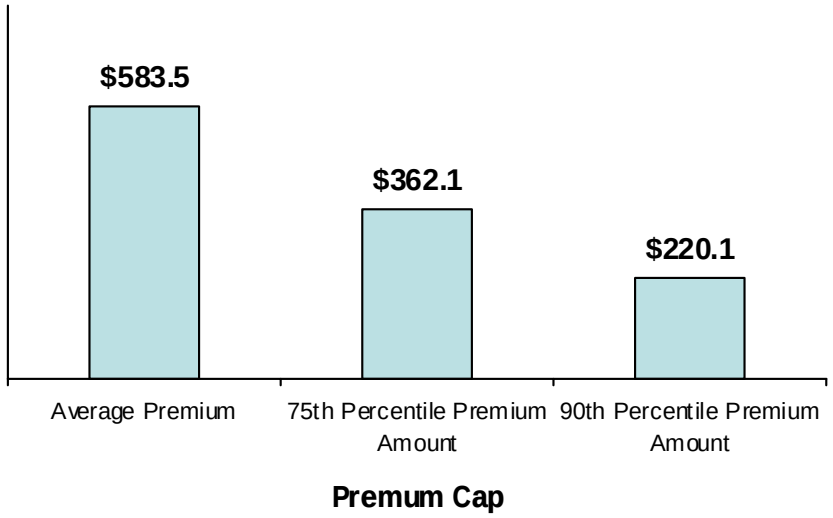
3 On average, a one percent increase in the price of an insurance product causes about 2.5 percent of members to shift to lower cost products. No savings are calculated for people currently in HMOs. See: Stombom, B.,Buchmueller, T.,Feldstein, P. "Switching costs, Price Sensitivity and Health Plan Choice", Journal of Health Economics 21 (2002) 89-116.

4 Stapleton, D., "New Evidence on Savings from Network Models of Managed Care," (a report to the Healthcare Leadership Council), The Lewin Group, Washington, DC, May 1994

5 For a detailed discussion of methods see: "The Health Benefits Simulation Model (HBSM): Methodology and Assumptions," The Lewin Group, March 31, 2009.

The amount of revenues raised by capping the exclusion varies with the level of the cap. As shown above, capping the exclusion at average premium amount would raise $583.5 billion over the 2010 through 2019 period (***Figure 3***). If the cap is raised to the 75th percentile premium amount, revenues fall to $362.1 billion. At the 90th percentile, revenues fall to $220.1 for the 10-year period.

Figure 3
Revenues Raised under Alternative Caps on Employer Tax Exclusion for Employer-Sponsored Insurance: 2010 – 2019 (billions)



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

B. Increase Tax on Tobacco Products

Increasing the tax on tobacco products would raise revenues while reducing tobacco use. This reduction in tobacco use would improve health and reduce health care costs for tobacco related illnesses. Health care savings would accrue to all payers including federal programs. Thus, the tax on tobacco will raise federal revenues while reducing federal costs.

In this scenario, we assume that the federal cigarette tax is increased from $0.39 per pack to $2.39 per pack, with taxes on other types of tobacco products increased in the same proportion. Chaloupka et al. (2000) has estimated that for every 10 percent increase in the cost of a pack of cigarettes, consumption declines by 4 percent.[6] Given the current average retail price of $4.27 per pack, the proposed tax increase would result in an 18.8 percent decline in consumption above the current rate of decline in smoking prevalence.[7,8]

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[6] Chaloupka F, The-Wei Hu,Warner K, Jacobs R, Yurekli (2000). "The taxation of tobacco products", Report found at http://www1.worldbank.org/tobacco/tcdc/237TO272.PDF

[7] Report found at: http://tobaccofreekids.org/research/factsheets/pdf/0234.pdf

We estimated the reduction in health spending due to smoking cessation based upon studies of the impact of tobacco use on smoking. One study estimates that care for tobacco-related illnesses accounts for about 14 percent of national health expenditures.[9] Barendregt et al. (1997) estimated that health care costs decline in the first 15 years following cessation. They estimate that if all Americans were to stop smoking, there would be a 1 percent reduction in national health spending in the first year following cessation, and that savings would increase to 2.5 percent by the 5th year.[10]

The tax on tobacco products would reduce the federal deficit by $358.8 billion over the 2010 through 2019 period (***Figure 4***). This includes total revenues from the tobacco tax of $294.5 billion, and reduced health spending under federal programs of $67.2 billion. National health spending for all payers (i.e., employers, consumers and governments) would decline by $182.3.

Figure 4
Impact of Tobacco Tax Increase on Federal Revenues and Health Spending: 2020-2019
(billions)

	Changes in Federal Budget			Reduction in National Health Spending
Year	Increase in Federal Tobacco Tax Revenues	Savings to Federal Programs	Net Federal Impact	
2010	$30.7	0	$30.7	0
2011	$30.4	$1.7	$32.1	$4.9
2012	$29.5	$4.1	$33.6	$11.4
2013	$29.3	$5.5	$34.8	$15.0
2014	$29.1	$6.8	$35.9	$18.6
2015	$28.8	$8.2	$37.0	$22.1
2016	$28.7	$9.2	$37.9	$24.8
2017	$28.5	$10.0	$38.5	$27.0
2018	$28.3	$10.7	$39.0	$28.8
2019	$28.2	$11.0	$39.2	$29.7
2010-2019	**$291.6**	**$67.2**	**$358.8**	**$182.3**

Source: Lewin Group estimates.

C. Offsets to Federal Safety-net Programs

It is often argued that covering the uninsured will be relatively inexpensive because we are already providing large amounts of subsidized care through numerous federal, state and

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8 Cigarette consumption in the US peaked in 1980 at 631.5 billion cigarettes per year and has since declined to 378.6 billion cigarettes per year. See: 1993 -1996 US Department of Agriculture 1997-2005 Alcohol & Tobacco Tax and Trade Bureau, Bureau of the Census

9 Center for Disease Control (CDC), report found at: http://www.cdc.gov/nchs/ppt/hpdata2010/focusareas/fa27_tobaccopres.ppt#297,1,Slide 1

10 Due to improved health, people would live longer, resulting in an eventual net increase in health spending by the 15th year. See: Barendregt JJ, Bonneux L Van Der Maas PJ. "The Health Care Costs of Smoking." *The New England Journal of Medicine*, October 1997.

private sources. This creates an expectation that covering the uninsured will result in offsetting savings to various safety-net programs such as federal Disproportionate Share Hospital (DSH) payments, Federally Qualified Health Centers (FQHC), and various substance abuse and immunization programs.

However, while the need for such safety-net services would decline, these offsets would not occur automatically. Unless Congress acts to explicitly reduce funding for these programs, the spending will continue, regardless of the demand for safety-net services. Of course, reducing funding for these programs would be highly controversial.

Currently, both the Medicare and Medicaid programs provide additional payments to states that are typically paid to hospitals serving large portions of the uninsured population called Disproportionate Share Hospital (DSH) payments. Most of the payments under Medicaid go to hospitals, although much of this money is now used by states to fund coverage expansions (e.g., Massachusetts). The Medicare program also makes additional payments to hospitals serving large portions of the medically indigent population. Total DSH payments under Medicare and Medicaid will be about $19.5 billion in 2010 (***Figure 5***).

Figure 5
Federal Disproportionate Share Hospital Payments under Current Law 2010-2019

Year	Federal Disproportionate Share Hospital (DSH) Funds under Current Law (billions)		
	Medicare	Medicaid	Total
2010	$10.1	$9.4	$19.5
2011	$10.5	$9.7	$20.2
2012	$11.0	$9.9	$20.9
2013	$11.7	$10.2	$21.9
2014	$12.5	$10.5	$23.0
2015	$13.4	$10.8	$24.2
2016	$14.4	$11.0	$25.4
2017	$15.4	$11.3	$26.7
2018	$16.5	$11.5	$28.0
2019	$17.6	$11.8	$29.4
Total 2010-14	**$55.8**	**$49.7**	**$105.5**
Total 2010-19	**$133.1**	**$106.1**	**$239.2**

Source: CBO projections.

Federal Funding for other health services will be about $5.84 billion in 2009, including:

- Federally Qualified Health Centers: through the Health Resources and Services Agency (HRSA): $1.875 billion
- Health Care Delivery in Rural Areas $0.025 billion
- Substance Abuse and Mental Health Service Administration (SAMHSA) $0.351 billion
- HIV/AIDS treatment programs (Ryan White) $1.103 Billion
- Primary Care: Immunizations for Preventable Diseases $2.489 billion

In addition, the Veterans Administration provides about $5.4 billion in care to uninsured veterans.[11]

There would be a continuing need for some of these safety-net services, even with health reform. There would still be uninsured people including undocumented immigrants and the homeless. Also, some of the services provided under these programs are outside of the scope of services typically covered under private health plans, and would still be needed. Careful analysis of the impact of the coverage expansions under reform will be required to determine the appropriate reductions in funding for these programs.

Moreover, the need for the services provided under these programs often exceeds what can be provided at current levels of funding. For example, the VA could provide substantially more services to veterans if additional funds become available. Therefore it is unlikely that all of this safety-net funding would become available to fund coverage expansions even if all Americans become covered.

For illustrative purposes, we assume that about half of federal safety-net funding can be recovered and used to finance health reform. This would come to about $130.0 billion over the 2010 through 2019 period.

[11] Jack Hadley et. al, "Covering the Uninsured In 2008: Current Costs, Sources of Payment and Incremental Costs," *Health Affairs*, 27, no. 5 (2008).