House Health Reform Bill (H.R. 3962) Reduces Deficit

Long-Term Cost Growth to Slow with Successful Implementation of Initiatives

The Congressional Budget Office (CBO) is cautious in estimating the savings from various health reform initiatives, such as investments in preventive care, expansion of health information technology, payment system reforms, and the availability of a public health insurance option. Other analysts have found much greater long-term savings both to the federal government and to private employers and families from these initiatives.

Despite these constraints, CBO has concluded that **H.R. 3962 is fully funded and deficit neutral. In fact, CBO states that in the initial decade and in the decade to follow the House legislation will begin to reduce federal budget deficits.**

H.R. 3962 achieves budget neutrality and a slight improvement in the long-term fiscal health of the federal budget while achieving a guarantee of more affordable, quality health care for every legal resident in the United States. The bill is projected to achieve a dramatic two-thirds reduction in the population of uninsured (reducing the number by 36 million, or 7 million more than the Senate Finance Committee bill) *and* the House bill provides substantially greater affordability protections for low, moderate and middle-income families than does the Senate Finance Committee bill.[1]

Additionally, under H.R. 3962, actual long-term savings to the federal government – and to employers and families – are likely to be substantially greater than the CBO's "scoreable" savings as a result of numerous reforms contained in the legislation. Over time, these initiatives will curb health care cost growth for public and private payers. A number of the critical reform initiatives in H.R. 3962 – those identified as generating savings by the CBO and other initiatives CBO largely discounts as not achieving "scoreable" savings – are listed below.

H.R. 3962 Accomplishes Universal Coverage and Deficit Neutrality

According to the CBO analyses, H.R. 3962 achieves nearly complete coverage of U.S. citizens and legal residents, is fully funded, and does not increase the federal deficit.[2]

- The number of uninsured declines dramatically (96 percent of legal residents covered).
- The net cost of the House bill of $891 billion "would be more than offset by the combination of other spending changes, which CBO estimates would save $426 billion, and receipts resulting from the income tax surcharge on high-income individuals and other provisions, which [the Joint Committee on Taxation] and CBO estimate would increase federal revenues by $572 billion over that period."[3]
- The federal deficit is reduced by $109 billion over the 2010 – 2019 period.
- In the following decade, federal budget deficits would be slightly reduced relative to those under current law, with a total effect during that decade that is in a broad range between zero and one-quarter percent of GDP.[4]

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[1] http://hcfan.3cdn.net/286f39dd60ce46d895_19em6kz9p.pdf
[2] http://www.cbo.gov/ftpdocs/107xx/doc10710/hr3962Dingell_mgr_amendment_update.pdf
[3] http://www.cbo.gov/ftpdocs/106xx/doc10688/hr3962Rangel.pdf
[4] In Section 7 of H.R. 2920 (passed on 7/22/09), the Pay-As-You-Go Act of 2009, the House established "pay-as-you-go" rules that included the cost of a Medicare physician fix as a component of baseline government expenditures. As a result, the cost of the physician

CBO is Cautious in Scoring Long-Term Savings

- H.R. 3962 was determined to be budget neutral despite the very cautious methodology CBO analysts use to "score" savings.
  - For example, CBO discounts substantial literature showing that the health care system can save hundreds of billions of dollars through expanding prevention efforts, increasing the use of health information technology, improving primary care, injecting a public health insurance option to compete with private health insurers, and adopting other strategies.[5, 6, 7]
  - Several long-term payment reforms that the CBO indicates would change the spending trajectory – reforms that change incentives so we pay for value, not just volume – are in the House bill. These are initially classified as demonstrations or pilots, but the legislation gives the Secretary full authority to expand them if quality measures are met and budget neutrality is demonstrated. *Although this "test-first" approach reduces "scoreable" savings, to protect Medicare program enrollees the initiatives are designed first to be tested to ensure they work before changing the care/payment systems relied upon by 45 million seniors and persons with disabilities.*

CBO Scoring Reflects Savings to Government, Not the Health System as a Whole

- CBO's charge is to estimate the cost of the reform bill to the federal government. The reality is that health reform will benefit the entire health care system, increase the financial security of all American families, and strengthen the entire U.S. economy.
  - New federal spending will make investments in coverage, prevention, and disease management that will reduce growth in health care costs, including for those with private insurance. For example, the increased federal expenditures to expand Medicaid will greatly reduce the extent to which insured families pay higher costs to hospitals to subsidize uncompensated care for the uninsured. The current added cost-shift from the uninsured to the insured is estimated to be $1,100 per family per year.[8]
  - In 2003, a report by the Institute of Medicine (IOM) showed that the total financial benefit from universal coverage (including increased life expectancy and productivity) exceeds the total dollar cost of achieving universal coverage. The IOM estimated that the economic value of the healthier and longer life that an uninsured child or adult forgoes because of lack of health insurance ranges from $1,600 to $3,300 per additional year without coverage. For the roughly 41 million Americans without insurance in 2002, the

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payment fix was not offset. Enacting the physician fix will prevent a 21 percent reduction in Medicare physician payment rates from going into effect in 2010 and correct Medicare's physician payment formula for the long-term, rather than continue annual fixes. The Medicare physician fix is contained in H.R. 3961 and is being acted on separately from the health reform legislation.

[5] "Preventable causes of death, such as tobacco smoking, poor diet and physical inactivity, and misuse of alcohol have been estimated to be responsible for 900,000 deaths annually — nearly 40% of total yearly mortality in the United States. Moreover, some of the measures identified by the U.S. Preventive Services Task Force, such as counseling adults to quit smoking, screening for colorectal cancer, and providing influenza vaccination, reduce mortality either at low cost or at a cost savings." "Does Preventive Care Save Money?" Fielding J. E., Husten C. G., Richland J. H., Cohen J. T., Neumann P. J., Weinstein M. C., N Engl J Med 2008; 358:2847-2848, Jun 26, 2008 (http://content.nejm.org/cgi/content/full/358/7/661)

[6] Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities," Trust for America's Health, July 2008 (http://healthyamericans.org/reports/prevention08/Prevention08.pdf)

[7] Commonwealth Fund. "The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way."

[8] http://www.americanprogress.org/issues/2009/03/cost_shift.html

aggregate, annualized cost of diminished health and shorter life span ranged from $65 billion to $130 billion for each year of health insurance forgone, the IOM concluded.[9]

- Under health reform, the government will absorb much of the financial cost, but the benefit returns to the economy and society as a whole.

- Health care reform is not a one-time event. Whether scored as generating savings or not, it is crucial to put systems in place to achieve long-term savings: fixing a dysfunctional insurance market, bringing all persons into coverage by assisting low and middle income families, and providing mechanisms such as a public health insurance option to lower the trajectory of health care cost growth. H.R. 3962 achieves these objectives.

At the end of the day, the only way we are certain to fail at bending the cost curve is to fail to enact health reform.

Long-Term Savings Potential

Prevention

The medical literature is replete with findings that indicate the savings potential of increased preventive care and chronic disease management. Lessening the acute-care impact of chronic diseases in the pre-Medicare population and slowing disease escalation among the elderly can save $652 billion to $1.4 trillion over 10 years.[10] Reversing chronic disease trends could reduce health costs and increase productivity by $1.1 trillion annually by 2023.[11] CBO's underestimation of savings from smoking cessation drugs in Medicaid is another useful illustration. A recent study supported by the U.S. Centers for Disease Control and Prevention estimates that 11 percent of state Medicaid costs are attributable to smoking, at an annual cost of $22 billion.[12] There are five first-line medications proven effective for smoking cessation, and the use of pharmacotherapy is known to increase the likelihood of smoking cessation by 50 percent.[13] Despite the huge potential for savings and the proven effectiveness of the protocol, CBO estimates that lifting the current ban on coverage of smoking cessation drugs in Medicaid would *cost* $100 million.

Public Health Insurance Option

The CBO credited the inclusion of a public health insurance option as achieving direct savings to the federal government and putting downward pressure on private plan premiums in the exchange. But, the savings scored by the CBO are extremely modest when compared to the estimates of others, and the scored savings were further reduced under H.R. 3962 as compared to prior estimates for H.R. 3200 (the initial House bill).

The potential savings to employers and plan enrollees under a public option are clear as the Medicare example indicates.[14] The choice of a public health insurance option in an exchange marketplace will curb costs for its enrollees directly and more generally in the insurance market as private plans respond to heightened competition.[15]

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[9] Institute of Medicine. Hidden Costs, Value Lost. Consequences of Uninsurance Series, No. 5. Washington, DC: National Academies Press; 17 June 2003 (http://www.iom.edu/CMS/3809/4660/12313.aspx)
[10] http://www.healthways.com/trillions/
[11] http://www.chronicdiseaseimpact.com/
[12] http://www.cdc.gov/pcd/issues/2009/Jul/08_0153.htm
[13] http://www.jaoa.org/cgi/reprint/102/6/342.pdf
[14] Medicare per person spending increased 4.4 percent per year from 1997 to 2007 while private health insurance premiums grew 7.7 percent per person. Committee on Ways and Means, March 9, 2009.
[15] John Holahan and Linda Blumberg. "Is the Public Plan Option a Necessary Part of Health Reform?" Urban Institute, June 26, 2009.

Under the revised bill that passed the House (H.R. 3962), the CBO attributed only minimal savings to the public option ($5 billion). The CBO's estimated savings were reduced substantially from prior estimates because the revised House bill gives the Secretary greater flexibility in the rates to be established.[16] **Under the initial House bill (H.R. 3200), the savings level scored by CBO for the public option was reported to be $110 billion over the initial 10 years, a figure representing an approximate 10 percent overall reduction in the cost of the legislation.** In this initial version of the House bill, the Secretary was directed to use Medicare rates (plus 5 percent for physician services) in the public option for the first three years. In subsequent years, the Secretary was to set rates such that overall costs would not be greater than would be the case if the Medicare-based rates were to continue in place.

In evaluating H.R. 3962, the added flexibility provided to the Secretary in the rates to be established for the public health insurance option led the CBO to lower the projected savings dramatically. **The CBO assumes that the Secretary will pay the highest rates allowable instead of using her discretionary authority to establish lower rates, such as Medicare rates or rates between Medicare rates and private rates.** Ultimately, on implementation the public option could very well achieve savings significantly greater that those scored by the Congressional Budget Office.

Health Information Technology

The inefficiency of our current health care system is widely acknowledged, with botched, repeated or unnecessary testing that cost patients money and time and raises costs for the entire health system. Health information technology (HIT) is widely believed to reduce miscommunication and improve efficiency. In fact, a study by RAND Corp. estimates potential *annual* savings at $77 billion or more.[17] CBO projected very little in savings that might result from HIT investments approved for health care providers in the Economic Recovery package and in fact registered a cost of $18.3 billion under Medicare and Medicaid from payment incentives included to foster adoption of HIT.

Waste, Fraud and Abuse

The National Health Care Anti-Fraud Association estimates that 3 percent of all health care spending, or $68 billion, is lost to health care fraud every year. In Medicare and Medicaid alone, the number may be as high as $35.8 billion.[18] H.R. 3962 contains numerous provisions to reduce improper payments, including increasing funding and flexibility to combat fraud, enhancing penalties for fraud and abuse, empowering the Secretary to impose provider screening or other firewalls in supplier or service categories at significant risk of fraud, increasing provider and supplier reporting, and expanding data collection to better identify fraud and abuse. Despite these measures, CBO scores these provisions at a *cost* to the federal government.

[16] The CBO projected, "The difference in premiums between private plans and the public plan would vary geographically—but on average the public plan would be about 10 percent cheaper than a typical private plan offered in the exchanges."CBO. Letter to Chairman Rangel, July 14, 2009, page 5.
[17] http://rand.org/pubs/research_briefs/RB9136/index1.html
[18] John K. Iglehart."Finding Money for Health Care Reform — Rooting Out Waste, Fraud, and Abuse." http://content.nejm.org/cgi/content/full/NEJMp0904854

Main Elements of $427 Billion in Savings in H.R. 3962, as Scored by CBO[19]

(Negative numbers represent reductions in the federal budget deficit.)

- **- $154.3 billion:** Medicare Advantage reforms to eliminate overpayments.
- **- $144.1 billion:** Incorporating productivity improvements into Medicare Part A and B market basket updates.
- **- $67.0 billion:** Medicare Advantage interactions with other provisions in the bill.
- **- $54.7 billion:** Update and adjustments to Medicare home health payment.
- **- $42.3 billion:** Changes to the Medicare Part D program that would expand drug coverage to beneficiaries that are currently subject to a gap in coverage ("doughnut hole").
- **- $24.6 billion:** Medicaid pharmacy reimbursement and prescription drug rebate provisions.
- **- $23.9 billion:** Changes to Medicare skilled nursing facility payments.
- **- $9.3 billion:** Reducing potentially preventable Medicare hospital readmissions.
- **- $15.5 billion:** Extension of Secretarial coding intensity adjustment authority over Medicare Advantage plans.
- **- $14.3 billion:** Revisions of Medicare payment systems to address geographic differences.
- **- $10.3 billion:** Medicare Part A disproportionate share hospital (DSH) report and payment adjustments in response to coverage expansion.
- **- $10.0 billion:** Reduction in Medicaid DSH.
- **- $5.7 billion:** Accurate dispensing in long-term care facilities.
- **- $5.3 billion:** Update to Medicare inpatient rehabilitation facility payment.
- **- $3.4 billion:** Changes in Medicare payment for imaging services.
- **-$3.0 billion:** Eliminate copayment to encourage use of lower cost generic drugs.
- **- $2.6 billion:** Accountable care organization pilot program with authority given Secretary to expand.
- **- $1 billion:** Limitation on Medicare exceptions to the prohibition on certain physician referrals made to hospitals.
- **- $0.8 billion:** Changes in Medicare rental and purchase of power-driven wheelchairs.

Provisions in H.R. 3962 Likely to Produce Long-term Savings that Are Unscoreable or Have Short-term Costs, According to CBO[20]

- **$0 billion:** Negotiation of lower covered Part D drug prices on behalf of Medicare beneficiaries.
- **$0 billion:** Post-acute care services Medicare payment reform plan and expansion of existing Acute Care Episode bundling program.
- **$0 billion:** Institute of Medicine study of geographic adjustment factors under Medicare.
- **$0 billion:** Extension of reasonable cost contracts for Medicare Advantage plans.
- **$0 billion:** Improving risk adjustment for Medicare Advantage plan payments.
- **$0 billion:** Ensuring effective communication in Medicare to reduce health disparities.
- **$0 billion:** Waiver of deductible for colorectal cancer screening tests regardless of coding, subsequent diagnosis, or ancillary tissue removal.
- **$0 billion:** Require Medicaid and State Child Health Insurance Plan (SCHIP) providers and suppliers to adopt programs to reduce waste, fraud, and abuse.

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[19] http://www.cbo.gov/ftpdocs/107xx/doc10710/hr3962Dingell_mgr_amendment_update.pdf
[20] http://www.cbo.gov/ftpdocs/107xx/doc10710/hr3962Dingell_mgr_amendment_update.pdf

- **$0 billion:** Reduce waste, fraud and abuse in Medicaid and SCHIP managed care organizations.
- **$0 billion:** Requirement to report expanded set of data elements under Medicaid Management Information Systems (MMIS) to detect Medicaid and SCHIP fraud and abuse.
- **$0 billion:** Denial of Medicaid and SCHIP payments for litigation-related misconduct.
- **$0.1 billion:** Improvements to Medicare durable medical equipment program.
- **$0.1 billion:** Tobacco cessation in Medicaid.
- **$0.1 billion:** Reduce waste, fraud and abuse in Medicaid and SCHIP overpayments.
- **$0.3 billion:** Application of quality measures.
- **$0.3 billion:** Translation or interpretation services in Medicaid.
- **$0.4 billion:** Medicare physician payments for efficient areas.
- **$0.5 billion:** Medical home pilot program in Medicaid.
- **$0.5 billion:** Inclusion of public health clinics under the Vaccines for Children program.
- **$0.8 billion:** Optional coverage of nurse home-visitation services in Medicaid.
- **$1 billion:** Comparative effectiveness research.[21]
- **$1.1 billion:** Comparative effectiveness research (effects on outlays in Medicare and non-Medicare).
- **$1.5 billion:** Expanding access to vaccines under Medicare.
- **$1.5 billion:** Medicare graduate medical education funding.
- **$1.8 billion:** Medicare medical home program with authority given Secretary to expand if proven beneficial.
- **$2.7 billion:** Coverage and waiver of cost-sharing for preventive services.
- **$4.7 billion:** Payment incentive for selected primary care services.
- **$10.7 billion:** Required coverage of preventive services in Medicaid.
- **$31 billion:** Establishment and administration of the exchange to provide a competitive marketplace.
- **$33.4 billion:** Public health investment fund and prevention and wellness trust.
- **No score:** Savings from increased health care fraud and abuse account (HCFAC) spending.

Provisions in Recent Legislation Likely to Produce Long-term Savings that Have Short-term Costs, according to CBO

- **$18.3 billion:** Establish payment incentives in the Medicare and Medicaid programs to encourage providers to adopt health information technology (HIT).[22]

[21] http://www.commonwealthfund.org/~/media/Files/Publications/Policy%20Points/2009/Options%20for%20Financing/1291_Mika_OptionsPolicy%20Points_623.pdf

[22] Contained in the American Recovery and Reinvestment Act of 2009 http://www.cbo.gov/ftpdocs/99xx/doc9968/hr1.pdf`