Can We Capture Potential Health Care Savings Without A Federal Takeover?

by David V. Axene

Most proposals for reforming the U.S. health care system of today focus on reducing the high cost of care. The standard thought process assumes that reducing costs will increase access to care by improving the affordability of health care and perhaps funding more care for the uninsured. An endless number of proposals focus on this issue. In fact, most of today's initiatives are based upon lowering costs and/or "bending the trend." Too few proposals address the core of this essay, "How do we capture those savings?"

Most insured and/or government run programs directly capture savings since the programs are directly and independently funded by premiums and/or taxes and savings result in surplus that can be readily captured. Self-funded, most experience-rated and self-pay programs create much more challenging issues. The reduced cost flows directly back to the entity or individual without being captured for broader public policy uses. Who owns these "saved" funds? Is it the employer, the covered employees, the labor union, the individual? The plan sponsor very much considers these dollars as its own. After all, it reduced its cost of care; therefore, it is the plan sponsor's money! Plan sponsors cringe during discussions about potential taxes on such programs since they view their right to self-fund the coverage an important freedom.

Capturing Savings

The challenging public policy dilemma becomes how to capture savings achieved through health care reform efforts without bringing all programs in under a common umbrella—the end result being to accumulate savings to fund broader initiatives. Is there a solution that accomplishes this without painful aggregation? Is it possible to do this without nationalizing the entire health care system?

Today there are more than 45 million uninsureds in the United States. With the challenging economy and increased job loss, this number is expected to increase. It is in our country's best interest to minimize the number of people without health insurance. To the extent that funds within today's delivery system can be used to pay for the cost of the uninsured, it seems a wise choice to use these funds to do so. Studies of the existing U.S. health care system show several opportunities to reduce the cost of care including improvements in efficiency and individual health status, as well as focusing on wellness, reduction in unnecessary administrative costs, and the introduction of technology to improve the efficiency of our record-keeping (e.g., electronic medical records). The new administration's direction to date is to pursue many, if not all, of these.

If we assume that any or all of these initiatives are successful at reducing the cost of health care, monies will be available only if they can be captured and used elsewhere in the system. Unfortunately, much of this money is filtered through a variety of mechanisms and may never be seen as cost savings. In the case of an insured program, the money shows up as reduced future premium rates. In the Medicare program, the money shows up as reduced costs. With significant deficits and Medicare program funding concerns, these funds may be gobbled up prior to being applied for other purposes. The already mentioned self-funded employer absorbs the savings as a reward for their willingness to assume risk.

Reducing The Number Of Uninsureds

One approach to eliminate uninsureds and fold them into the overall health care system is to mandate that everyone have health coverage of some kind. This is not unlike the mandates in most states where everyone is required to have some type of car insurance. Under this approach, those without coverage would be required to purchase coverage either through their employer or from another insurance source. To be successful, this would require a viable market for individuals to purchase coverage, the resources for individuals to purchase such coverage, and some way to measure the impact on providers of care who have either waived charges in the past or substantially reduced them in response to an individual's lack of coverage. To further reduce the burden for individuals to purchase coverage, potential delivery system cost reductions could be used to subsidize the cost or to reduce the underlying claims and/or administrative cost of the coverage. Everyone's cost

to obtain health coverage should go down if more people are covered by some form of health benefit plan—there would be significant savings just from the reduced write-offs of health care providers. The combination of capturing some of the cost savings with the inherent reductions from broadening coverage is key to funding such an initiative during challenging financial times.

Potential Approaches

So how do we capture the savings? Assuming the likely savings could be accurately predicted, one approach takes the form of a tax. For discussion purposes, let's assume that the cost-saving initiatives can save 10 percent and the elimination of the uninsureds an additional 5 percent from reduced provider costs. Each insurance company would be required to pay a tax to fund the savings, equivalent to 15 percent of the cost, or reduce premiums by an equivalent amount. Plan sponsors/individuals would pay an equivalent tax, while at the same time, providers would be required to reduce their net fees by 5 percent since their uninsured write-off would not exist. (This might be used to subsidize the cost of the uninsured). To be equitable for all individuals, the self-funded employer or health and welfare trust would have a similar tax since there is no insurance company involved. The likelihood of such a tax, or the disbelief that the cost savings would actually result in savings, or the reaction by carriers and providers to continue to increase costs until savings emerges, etc. would, for the short-term, increase the cost of care, thus dismantling much hope of reforming the system overall.

Another alternative might take the "Hawaii" approach, in which all employers are required to provide coverage and those not employed are required to obtain coverage elsewhere, either by purchasing an individual policy or enrolling in a public health program. Benefit plans are standardized to ensure that coverage is adequate. With this course of action, enrollment in public programs would increase, and some tax increases might occur, but clearly the number of uninsured would be dramatically reduced. Individual businesses would pick up a substantial portion of the cost of this mandate since they have to provide benefits to their employees. Any savings that emerge flow directly to the benefit plan sponsor. This indirectly captures the cost.

The only other alternative is the establishment of a nationalized health care program where everyone is covered, everyone has benefits and the cost of the program is funneled through a single government agency. Other countries pursuing this have funded this through specific taxes. Cost savings automatically are captured. This doesn't necessarily have to impact employer-sponsored plans as long as the employer continues to contribute to the program. The tax deductibility to the business of these contributions is key to this approach.

In summary, it is very challenging to capture cost savings without nationalizing the health care system. Today's patchwork quilt model—where individuals and individual business have the choice to do what they want and how they want to do it—provides considerable flexibility but fails to meet the important public policy objective of universal coverage for all.

David V. Axene, FSA, MAAA, FCA, is president of Axene Health Partners, LLC, in Winchester, California. He can be reached at david.axene@axenehp.com.