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Boosting the Economic Prospects of Working Families Without Bankrupting America

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How to Help Working Families without Bankrupting America

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INTRODUCTION

Americans are drowning in debt, both privately and collectively. Last summer, the national debt topped $22 trillion. On the private side, total U.S. household debt hit $13.6 trillion in 2019 – driven by higher student loan, credit card, mortgage, and auto loan debt.[1]

No wonder most Americans are having trouble making ends meet. According to one survey, 8 of every 10 Americans continue to live paycheck-to-paycheck.[2] With so many Americans struggling, it's imperative that the next President and Congress focus on ways to help Americans not just to make more money, but also keep more of what they earn.

Republicans argue the answer is tax cuts. But under the "Tax Cuts and Jobs Act" (President Donald Trump's signature achievement), 82.8 percent of the benefits are going the top 1 percent. The federal deficit has soared because the miraculous growth Republicans promised hasn't materialized. This implies rising tax burdens on working and middle class families.[3]

Meanwhile, some Democratic candidates are calling for strikingly ambitious new spending programs, despite the nation's deteriorating fiscal condition. These include single payer health insurance, free college, student loan forgiveness, and a federal jobs guarantee – and their cumulative price tag is staggering. The jobs guarantee alone is estimated to cost over $500 million a year.[4] Progressives at least have a theory for how to pay for all this – tax the rich – but their fiscal blueprints don't quite add up.

What's more, some of the new proposed government spending could also have unintended consequences and make some problems harder to solve. For example, take the relationship between the rising cost of college tuition and the federal student loan program. While student aid certainly has helped to increase access to higher education for millions of Americans, over time it also acts as an indirect subsidy to colleges and universities that makes it easier for them to raise tuition with little or no repercussions. That's one reason average student loan debt today has reached $37,172 and more millennials and post-millennials are having to choose between an education vs. saving for retirement or buying a home.[5]

Instead of spending more through the tax code or government programs, policymakers need to ensure that existing subsidies are not simply being passed through to third parties. The key is to make sure markets are functioning competitively, and if they are not, addressing the causes. In some cases, this may require government intervention to prevent anti-competitive behavior (for example, to counteract concentration in the health care delivery sector). In others it might mean streamlining regulations that are creating shortages, say in affordable housing. In higher education, lawmakers should focus on getting college costs down rather than delivering ever-higher subsidies to try to catch up with soaring tuition.

This report offers three ideas for helping relieve financial strains on working and middle class families without plunging either them or our government deeper into the red. Specifically, we propose to cap prices for private medical services; to deregulate housing markets; and to move U.S. colleges and universities toward three-year bachelor's degrees.

CAP OUT-OF-NETWORK PROVIDER PRICES IN THE PRIVATE INSURANCE MARKET

The price of health care has been rising 2 to 3 times faster than wages and in 2017 the amount families paid to get health care reached $26,944, according to the Milliman Medical Index—nearly $9,000 higher than in 2010, when the Affordable Care Act (ACA) was enacted. As a result, Americans have been effectively paying a 4.5 percent payroll tax toward health care coverage.

The high cost of health care in the United States is primarily due to high prices. One reason prices are higher in the U.S. than other countries is because providers are paid more – including physicians and hospital administrators – and goods like biopharmaceuticals and medical devices are more expensive.[6] On average, U.S. hospital prices are 60 percent higher than countries in Europe[7] and physicians make twice as much as their counterparts in other advanced countries.[8]

One reason the U.S. has such high prices is the lack of bargaining power among health plans.[9] The U.S. health system has never had perfect price competition and purely free markets. Since the 1960s, it has been a hodgepodge of public insurance like Medicare and Medicaid alongside private employer-based coverage and, as a last resort, individually purchased coverage.

Over the last decade, the public side of the U.S. health system has had some successes in controlling medical inflation. Medicare costs moderated a little, as price increases were held down and hospital utilization stabilized. Seeking better benefits and lower out-of-pocket costs, Medicare beneficiaries increasingly switched from Medicare's traditional fee-for-service program to private Medicare Advantage plans, which, in turn, often use innovative, value-based reimbursement and seek to better coordinate care, particularly for patients with chronic or long-term health conditions.[10]

However, Medicare Advantage plans are excelling precisely because of Medicare's out-of-network price cap.[11] Based on data from the mid-2010s, the Congressional Budget Office (CBO) reported that while commercial payment rates for hospital care averaged nearly 190 percent of Medicare's rates, Medicare Advantage plans' in-network rates were very close to those of Medicare, because Medicare Advantage plans' rates are capped at Medicare rates for out-of-network care.[12]

While Medicare Advantage has flourished, the on-going battle to keep costs down for private employer-based and individual coverage has largely been lost. Hospitals have continued to consolidate into large regional chains, often purchasing physician groups in the process. As a result, hospital prices faced by private insurers have risen to at least 200 percent of Medicare rates, and physician rates have also risen toward unsustainable levels.[13][14] To hold down premium increases in the face of continually higher prices, employers have raised deductibles, co-pays and premiums.

That's why PPI believes it is time to learn from the Medicare Advantage experience and extend price caps to private health care markets.[15] In theory, today's large integrated health systems can improve quality by reducing unnecessary and duplicative care. In practice, however, the potential efficiency gains from integration have been swamped by the concentration of providers' pricing power. Private insurers pay widely varying prices both across and within local health care markets, which suggests that they have little leverage with providers.[16]

Contrary to what some Democrats are argue, we don't need to enroll every American in Medicare to benefit from its pricing schedule. PPI proposes leveraging Medicare's bargaining power on behalf of consumers and private insurers by setting a maximum rate on what providers can charge payers for out-of-network care. All commercial health plans would have the option of using these default prices for all emergency and out-of-network claims, and all health care providers would be required to accept them. Providers would be prohibited from passing the costs onto consumers through balance billing for emergency services (for which patients cannot shop around) or any non-emergency service without adequate price disclosure in advance.

These price caps would reduce costs for both in-network and out-of-network care because insurers would have little incentive to bring providers into their network at rates significantly higher than the default price. Knowing that they can only receive a limited payment for each service rendered, providers may also be incentivized to move away from fee-for-service arrangements altogether and enter into contracts that reward outcomes and efficiency of care over the number of services provided.[17] For example, in the Medicare Advantage program, which also has price caps, health plans are encouraged to compete on quality and cost. In Medicare Advantage, physician rates are capped at the default fee-for-service rates, but plans can reward providers who deliver better quality care, help manage utilization, or differentiate themselves in other ways. Thus the cap encourages cost-effective, quality care.[18]

Savings achieved from reducing health care prices would be passed on to consumers in the form of lower premiums because of the ACA's medical-loss ratio (which caps the share of premiums that can be spent on administration instead of paying for services). Lower premiums would then reduce government spending on ACA premium subsidies and reduce employer spending on health coverage. Because spending on employer-sponsored insurance premiums is given preferential tax treatment, this reduction in employer premium spending will translate to higher taxable incomes and thus more federal revenue.

PPI proposes that the average rate cap under this policy should start at 200 percent of current Medicare rates then be reduced by 10 percentage points per year until the default price reaches 120 percent of Medicare reimbursement rates. We estimate that capping out-of-network bills to these rates would cut health care costs in the commercial market by almost half.[19] **If the rate cap is successful in achieving the anticipated reductions, families could save thousands of dollars a year.**

Putting into place cost controls is obviously not the preferred strategy for well-functioning markets and is not a step we take lightly. But the fact remains that the private insurance market has been unable to impose reasonable limits on what Americans have to pay for medical services, and therefore for health insurance. By capping prices above what Medicare rates, our plan would apply greater price discipline over time, so that providers wouldn't see a precipitous decline in their earnings. We believe our approach would facilitate the move away from fee-for-service towards a more efficient model for rewarding high-value, innovative health care.

And unlike single payer proposals, this approach would build on the successes of ACA, expanding coverage further and creating new incentives to push costs down without forcing 155 million Americans to give up their private health insurance.

REDUCE RESTRICTIVE ZONING AND REGULATIONS ON HOUSING

In an era where young people are flocking to cities, exclusionary zoning and land use policies are severely constraining the supply of affordable housing. Increasingly, middle class families simply cannot afford to live in high-growth metro center. A Not In My Back Yard (NIMBY) spirit prevails in many of our most "progressive" cities, preventing multifamily housing development through mechanisms like capping the height at which apartments can be built or requiring a minimum number of parking spaces per development. Prohibitions against infill housing and misuse of historic preservation rules are taking up land that could otherwise be used for units of housing.

Furthermore, empty lots available for development are becoming increasingly scarce, particularly in high-cost urban areas like New York, Los Angeles, and San Francisco. The combination of zoning rules and scarce land is a major contributor to higher rental prices.

A report from McKinsey found that it is possible **to reduce the cost of housing anywhere between 20 to 50 percent** by unlocking public land that is unoccupied or underused for affordable housing, and by increasing density, such as raising the permitted floor space on a plot of land.[20]

Breaking down other NIMBY policies could do much to bring down the cost of housing, particularly in urban centers. A few Democratic presidential candidates have embraced this idea. One way to do this without incurring major new costs is to leverage existing federal aid to urban and inner suburban communities by tying participation in those programs to reducing NIMBY barriers. Participation in the Community Development Block Grant, the New Starts and Small Starts program, and participation in the Opportunity Zones could all have prerequisites that localities have in place a menu of policies that would reduce regulatory barriers that delay and restrict the construction of new affordable housing units. These would include:

- Raising height restrictions;
- Relaxing constraints on density;
- Removing mandatory parking space requirements;
- Allowing for accessory dwelling units;
- Limiting the use of historic designations.

None of this is to suggest that the market alone will solve all our affordable housing problems. We will still need a vigorous public housing program that includes Section 8 Vouchers, the Low-Income Housing Tax Credit, the Home Investments Partnerships Program, and efforts to protect existing affordable housing. In addition, income support policies such as the Earned Income Tax Credit and a higher minimum wage should also be included as part of an overall affordable housing strategy.

But supply matters. Increases in the supply of dwellings at all price points can help push rents down for everyone. That's why policymakers should make it easier to build housing to increase competition among builders and reduce prices for renters.

MOVE TOWARD THREE-YEAR COLLEGE

College costs too much, takes too long to complete, and isn't aligned effectively with the skills needed to excel in the job market.

One way to cut costs is to push U.S. colleges to move from four-year to three-year degree programs. Three-year degree programs are common in much of Europe, and students who graduate with bachelor's degrees from prestigious institutions such as Oxford, Cambridge, or the London School of Economics typically do so in just three years. Transitioning to a three-year degree system would force universities to review their curriculums and cut unnecessary degree requirements that pad educational expenses for students without enhancing the value of their degree. **Making 3-year bachelor's degree the norm could slash the cost of tuition, fees, room & board by up to 25 percent.**

The most aggressive version of this reform would be to give colleges and universities up to 10 years to adjust their curriculums, after which point the federal government would cut off federal support for students who attend four-year degree programs (except for those in complex fields for which there is little fat to cut in existing curriculums, as determined by a waiver system developed by the Department of Education). Three-year programs could be designed in several ways to meet this requirement. Schools could move to a trimester system by adding to the school year, offer summer courses at no additional cost, or redesign their curriculum and adjust credit hours. To ensure the savings accrue to students and their families, federal aid would only be available for three years' worth of college, and tuition and fee increases would not be allowed to rise above a formula set by the Department Education in conjunction with representatives of the higher education community.

But there are also less invasive measures the federal government can take in pursuit of the same goal. The government could require universities to award college credit for Advanced Placement (a score of three or higher), International Baccalaureate, and other college-level coursework completed by students in high school. PPI supports increasing federal, state, and local funding for these programs in underserved communities to better prepare students for college and raise graduation rates. Improving graduation rates is essential to alleviating the student debt burden because half of students who fail to graduate accrue more federal debt over the first seven years of their repayment than they initially borrowed because they are unable to make loan payments that keep up with interest.[21]

Schools could also give students credits for work experience and internships even if those jobs paid wages. And universities could create accelerated bachelors/masters degrees where students would commit to spending 5 years in school but would get both degrees in a shorter amount of time than if they did them separately.

The government could also place restrictions on tuition increases at universities receiving federal funding and tighten accreditation standards to close dropout factories. The Department of Education only grants federal aid to students attending colleges and universities that are recognized by approved accreditors. While graduation rates do not demonstrate everything about a school's quality, the government spent $15 billion in non-tax student aid on colleges and universities that had six-year graduation rates below 15 percent in 2014.[22] The Department of Education should consider requiring accreditors to only recognize colleges and universities that can prove they improve students' outcomes, allowing students who would otherwise waste money at these institutions to get a proper education elsewhere.

To make the savings to families go further, most existing assistance for higher education (tax incentives, Pell, other programs) could be combined into a new Super Pell Grant worth $6,200.

TABLE 1: FEDERAL SUPPORT FOR HIGHER EDUCATION

PROGRAM(S)	EXPENDITURES FY 2018
PELL GRANTS AND FSEOG	$30.6 Billion
TAX CREDITS	$18.8 Billion
PREFERENTIAL TAX TREATMENT FOR STUDENTS AGES 19 TO 23	$7.7 Billion
TAX EXCLUSIONS	$7.7 Billion
TAX DEDUCTIONS	$2.5 Billion
WORK STUDY/EDUCATION OPPORTUNITY GRANTS	$1.9 Billion
TRIO/GEAR UP/OTHER STUDENT ASSISTANCE	$2.4 Billion
TOTAL	$71.6 Billion

Consolidating all the higher education tax breaks, Pell Grants, and Work Study funding (the student loan program would remain as is) into a single grant for the 65 percent of all students attending an accredited college or university, would accomplish two progressive goals. First, it would vastly simplify the process of applying for and using student aid and make public subsidies more transparent. Second, merging all these funding streams would enable Washington to provide around 11.9 million students with federal aid worth $5200 annually. This would be 4.9 million more than the current number of Pell recipients and would be worth more than $1000 that the average Pell Grant.

The combination of the Super Pell and 3-year college would provide considerable savings to most students.

TABLE 2: TUITION COST SAVINGS FROM THREE-YEAR DEGREE AND SUPER PELL GRANT

SCHOOL TYPE	TOTAL TUITION AND FEES CURRENT SYSTEM 2018	TOTAL TUITION AND FEES UNDER 3 YEAR DEGREE	SUPER PELL GRANT	SAVINGS TO QUALIFIED STUDENTS
PUBLIC 4 YEAR-IN-STATE	$9,970	$7,477	$5,200	$7,693
PUBLIC 4 YEAR-OUT-OF-STATE	$25,620	$19,215	$5,200	$11,605
PRIVATE NONPROFIT FOUR-YEAR	$34,740	$26,055	$5,200	$29,202

While the adjustment to a 3-year degree would be challenging and time-consuming, the many benefits would outweigh the costs to the U.S. economy. Students would have to carry less debt and could enter the work force earlier. Both results would help to grow the economy and restore the American Dream for a new generation.

CONCLUSION

Taken together, these three ideas would help average working families get ahead without compounding America's public or private debt problems. By cutting health care prices, removing unfair regulatory obstacles to building more affordable, middle class housing, especially in our most dynamic cities, and reducing the cost (and duration) of college by 25 percent, they would help Americans keep more of what they earn. They constitute a radically pragmatic agenda for advancing upward mobility without the specter of higher debt, higher taxes and higher interest rates.

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References

1 Federal Reserve Bank of New York, "Household Debt and Credit Report," Q1 2019.

2 Nick Cardona, "Nearly 8 out of 10 Americans Living Paycheck to Paycheck," USA Today, August 24, 2017.

3 Dylan Matthews, "The Republican tax bill got worse: now the top 1% gets 83% of the gains," Vox, December 18, 2017.

4 David Weigel and Jeff Stein, "Democrats, emboldened by GOP cuts and policies, back bigger government," Washington Post, May 27, 2018

5 Zach Friedman, "Student Loan Debt Statistics In 2018: A $1.5 Trillion Crisis," Forbes, June 13, 2018

6 Irene Papanicolas, Liana R. Woskie, and Ashish K. Jha, "Health Care Spending in the United States and Other High-Income Countries," JAMA Network, March 13, 2018, https://jamanetwork.com/journals/jama/article-abstract/2674671

7 Francette Koechlin, Luca Lorenzoni, and Paul Schreyer, "Comparing Price Levels of Hospital Services Across Countries," Organisation for Economic Cooperation and Development, July 10, 2010, https://www.oecd-ilibrary.org/social-issues-migration-health/comparing-price-levels-of-hospital-services-across-countries_5km91p4f3rzw-en

8 Miriam J. Laugesen and Sherry A. Glied, "Higher Fees Paid to US Physicians Drive Higher Spending For Physician Services Compared to Other Countries," Health Affairs, September 2011, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0204.

9 Data show that private insurers pay widely varying prices both across and within local health care markets implying that they have little leverage with providers.
"Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets," National Academy of Social Insurance, April 2015, https://www.urban.org/sites/default/files/publication/50116/2000212-Addressing-Pricing-Power-in-Health-Care-Markets.pdf

10 Susan Morse, "How Medicare Advantage steers the Silver Tsunami into coordinated, value-based care," Healthcare Finance, March 28, 2019. https://www.healthcarefinancenews.com/news/how-medicareadvantage-steers-silver-tsunami-coordinated-value-based-care

11 John Holahan, Laura Skopec, Erik Wengle, Linda J. Blumberg, "Why Does Medicare Advantage Work Better Than Marketplaces? Urban Institute, January 30, 2018. https://www.urban.org/research/publication/why-does-medicare-advantage-work-better-marketplaces/view/full_report.

12 Jared L. Maeda and Lyle Nelson, "An Analysis of Private-Sector Prices for Hospital Admissions," Congressional Budget Office, April 2017. https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/52567-hospitalprices.pdf

13 Chapin White and Christopher Whaley, "Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative," RAND Corporation (2019). Available at: https://www.rand.org/pubs/research_reports/RR3033.html.

14 Daria Pelech, "An Analysis of Private-Sector Prices for Physicians' Services," Congressional Budget Office, January 2018. https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/53441-workingpaper.pdf

15 "Consolidation in California's Health Care Market 2010-2016: Impact on Prices and ACA Premiums," Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, March 26, 2018, http://petris.org/wp-content/uploads/2018/03/CA-Consolidation-Full-Report_03.26.18.pdf

16 "Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets," National Academy of Social Insurance, April 2015. https://www.urban.org/sites/default/files/publication/50116/2000212-Addressing-Pricing-Power-in-Health-Care-Markets.pdf

17 Susan Morse, "How Medicare Advantage steers the Silver Tsunami into coordinated, value-based care," Healthcare Finance, March 28, 2019, https://www.healthcarefinancenews.com/news/how-medicareadvantage-steers-silver-tsunami-coordinated-value-based-care

18 Aaron Glickman, Claire Dinh, and Amol S. Navathe, "The Current State of Evidence on Bundled Payments," Leonard Davis Institute of Health Economics, October 8, 2018, https://ldi.upenn.edu/brief/current-state-evidence-bundled-payments

19 Ben Ritz and Brendan McDermott, "Funding America's Future: A Progressive Budget for Equitable Growth," Progressive Policy Institute, July 2019. https://www.progressivepolicy.org/projects/center-for-funding-americas-future/budgetblueprint/

20 Jonathan Woetzel, Sangeeth Ram, Jan Mischke, Nicklas Garemo, and Shirish Sankhe, "Tackling the world's affordable housing challenge," McKinsey Global Institute, October 2014

21 Michael Itzkowitz, "Want More Students To Pay Down Their Loans? Help Them Graduate," Third Way, August 2018. https://www.thirdway.org/report/want-more-students-to-pay-down-their-loans-help-them-graduate

22 Michael Dannenberg and Maru Nguyen Barry, "Tough Love: Bottom-Line Quality Standards for Colleges," The Education Trust, 2014.

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