



Bending the Health Care Cost Curve: Focusing Only on Federal Budget Outlays Won't Solve the Problem

By Karen Davis, Cathy Schoen, and Stuart Guterman

The start of the new Congress and the State of the Union address have renewed debate over how best to reduce the federal budget deficit and control health care costs. Recently released budget-reduction proposals, most notably from the National Commission on Fiscal Responsibility and Reform, cochaired by Alan Simpson and Erskine Bowles, and the Bipartisan Policy Center's Debt Reduction Task Force, cochaired by Pete Domenici and Alice Rivlin, include options for reducing federal health spending (Exhibit 1). These proposals contain some recommendations that merit exploration, but their focus on reining in federal spending, rather than controlling health spending overall, could simply shift costs from the federal government to state and local governments, businesses, and families.

There is no question that federal health care programs constitute a large and growing portion of the federal budget. Federal health spending represented 23 percent of the federal budget in 2010, mostly for the Medicare and Medicaid programs, and that proportion is projected to rise to 29 percent by 2020. As a proportion of the nation's economy, federal health outlays are expected to increase from 5.5 percent of gross domestic product (GDP) in 2010 to 7 percent by 2020. Similarly, total health expenditures, both government and private, are expected to rise faster than the GDP, increasing from \$2.6 trillion in 2010 to \$4.6 trillion in 2019 (Exhibit 2). Given that the underlying cause is rising health care costs, bringing federal health spending under control will require changes not only in public programs but also in the private sector.

Moreover, it is important to recognize that the current federal deficit is the product not only of historically high federal outlays but also historically low federal revenues (Exhibit 3). Since 1950, federal tax revenues have averaged

17.9 percent of GDP, while expenditures have averaged 19.9 percent. In 2010, while outlays were 23.8 percent of GDP—3.9 percentage points above the average over that period—revenues were 14.6 percent, or 3.3 percentage points below the average over the previous 60 years. This was because of the economic contraction as well as cuts in tax rates over the last decade. A balanced approach to managing the deficit would restore revenues as well as look for opportunities to control federal budget outlays.

Below, we outline some of the key features of the recent deficit reduction proposals as they relate to health care. There are several common elements, such as limiting the federal government's contributions to Medicare enrollees' medical costs by restructuring the program's cost-sharing rules; increasing rebates on drugs provided under the Medicare prescription drug program; and enacting malpractice reforms. Others go further in calling for conversion of Medicare into a voucher system rather than an insurance program and changing Medicaid from a shared federal-state matching program to a federal fixed-budget block grant to states.

Report of the National Commission on Fiscal Responsibility and Reform

The options considered by the National Commission on Fiscal Responsibility and Reform are estimated to achieve a total of \$4.1 trillion in federal budget savings through 2020, achieving a balanced budget by ensuring tax revenues and spending each comprise 21 percent of GDP. The Commission's report, *The Moment of Truth*, includes several short- and longer-term changes to the Medicare and Medicaid programs, as well as other health care financing reforms, which would produce an estimated \$74 billion in net savings through 2020, but larger savings thereafter.

A major challenge in managing the federal deficit is the sustainable growth rate (SGR) formula that now determines Medicare physician payment. This formula has mandated cuts in physician fees in every year since 2002—raising concerns about Medicare beneficiaries’ continued access to physician services—but those cuts consistently have been superseded by Congress on a temporary basis, while action to eliminate the underlying problem has been deferred. As a result, even freezing physician payment rates from 2012 through 2020 would increase Medicare spending by \$267 billion.

The Commission’s report calls for replacing the SGR by developing a new physician payment formula that would encourage care coordination and pay doctors based on their performance instead of the number of services they deliver. In the short term, cuts in Medicare physician fees would be replaced with a payment freeze through 2013 and a 1 percent cut in 2014, with the SGR to be reinstated until a new system is in place. These policies are estimated to save \$26 billion relative to a freeze on physician payment rates.

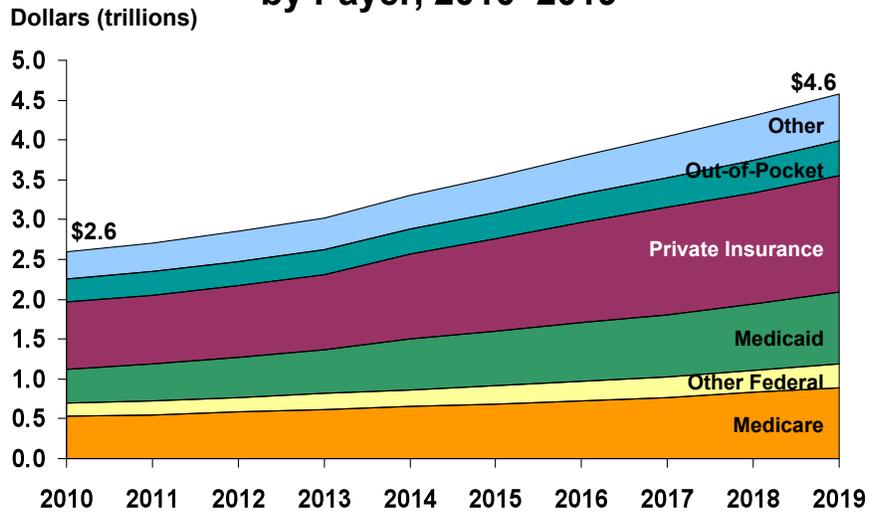
Exhibit 1. Major Health Policies in Deficit Reduction Proposals

National Commission on Fiscal Responsibility and Reform (Simpson–Bowles)		Bipartisan Policy Center Debt Reduction Task Force (Domenici–Rivlin)
Reform Sustainable Growth Rate mechanism for determining Medicare physician fee updates (costs \$240B)	Enact premium support pilot for federal employees (saves \$18B)	Phase out tax exclusion for employer-sponsored health insurance beginning in 2018 (saves \$113B)
Reform or repeal CLASS Act (costs \$76B)	Reduce Medicare fraud (saves \$9B)	Raise Medicare Part B premiums (saves \$123B)*
Extend Medicaid rebates to Medicare/Medicaid dual eligibles in Medicare Part D (saves \$49B)	Cut Medicare payments to providers for bad debts (saves \$23B)	Increase rebates for Part D drugs (saves \$100B)*
Reduce Medicare payments to hospitals for graduate medical education (saves \$60B)	Accelerate home health payment changes in the Affordable Care Act (saves \$9B)	Redesign Medicare cost-sharing (saves \$14B)*
Reform Medicare cost-sharing rules, cap beneficiary out-of-pocket spending, restrict first-dollar coverage in Medicare supplemental insurance (saves \$110B)	Place dual eligibles in Medicaid managed care (saves \$12B)	Bundle Medicare payment for acute and post-acute care (saves \$5B)*
Restrict first-dollar coverage in TRICARE for Life (saves \$38B)	Reduce funding for Medicaid administrative costs (saves \$2B)	Transition Medicare to premium support, beginning in 2018 (saves \$172B)
Enact malpractice reform (saves \$17B)	Broaden scope of Independent Payment Advisory Board to all federal health spending	Eliminate barriers to enrollment in managed care options for dual eligibles (saves \$5B)*
Eliminate use of provider taxes to generate additional federal matching payments for Medicaid (saves \$44B)	Set global target (growth rate in per capita GDP plus 1 percentage point) for federal health spending beginning in 2020	Incentivize government to control Medicaid cost growth (saves \$20B)
		Cap noneconomic and punitive damages for malpractice (saves \$48B)
		Introduce excise tax on sweetened beverages (saves \$156B)

Estimates through 2020 unless otherwise indicated.

* Estimate through 2018.

Exhibit 2. National Health Expenditure Projections by Payer, 2010–2019



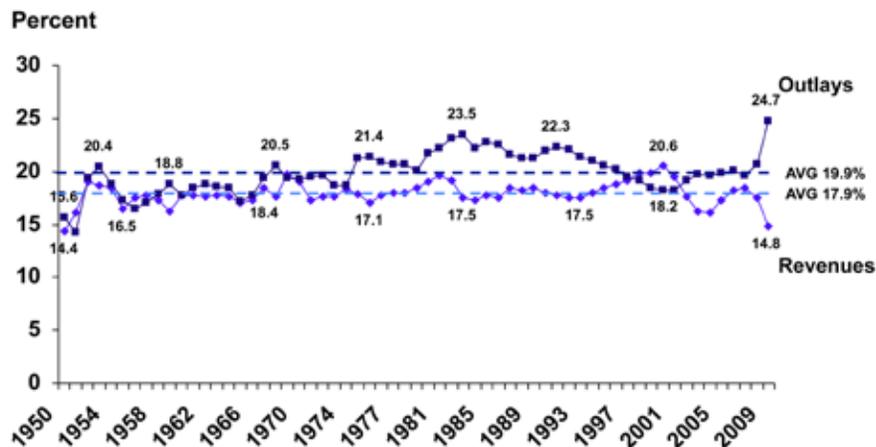
Source: National Health Expenditure Projections, Office of the Actuary in the Centers for Medicare and Medicaid Services.

In addition, the Commission’s report calls for reform or repeal of the Community Living Assistance Services and Supports (CLASS) Act, a voluntary long-term care insurance program that is part of the Affordable Care Act. While it’s been estimated that the CLASS Act will save \$76 billion through 2020 and is designed to be self-financing over time, some argue that it is not financially viable in the longer run.

The proposal includes other policy changes to offset the cost of reforming the physician payment system and repealing the CLASS Act, including the following (with their estimated impacts on federal spending through 2020):

- Reforming Medicare cost-sharing rules, capping beneficiary out-of-pocket spending, and restricting

Exhibit 3. Federal Revenues and Outlays as a Percentage of GDP, 1950–2009



Source: Office of Management and Budget.

first-dollar coverage in Medicare supplemental insurance (savings of \$110 billion).

- Reducing Medicare payments to hospitals for graduate medical education (savings of \$60 billion).
- Extending the Medicaid prescription drug rebates established in the health reform law to beneficiaries who are dually eligible for both Medicare and Medicaid and obtain their prescription drugs under Medicare Part D (savings of \$49 billion).
- Cutting Medicare payments to providers for bad debts (savings of \$23 billion).
- Eliminating the use of provider taxes to generate additional federal matching funds for state Medicaid programs (savings of \$44 billion).
- Implementing other Medicare and Medicaid changes (savings of \$32 billion).
- Restricting first-dollar coverage in TRICARE for Life, which provides health care coverage for military retirees and their families (savings of \$38 billion).
- Piloting premium support through the Federal Employees Health Benefits Program (savings of \$18 billion).
- Enacting malpractice reform, including a statute of limitations, the creation of health courts, and other tort law changes (savings of \$17 billion).

Additional savings beyond 2015 are to be achieved primarily by accelerating and strengthening provisions in the Affordable Care Act. These include expanding successful cost-containment pilots in Medicare, such as pay-for-performance programs and the bundling of post-acute care services. The Fiscal Commission's report also calls for strengthening the Independent Payment Advisory Board (IPAB), which was created in the health reform legislation to develop policies that limit the growth of Medicare spending beginning in 2015. The report recommends giving the IPAB authority to make recommendations regarding hospitals and other providers that are exempted under the law through 2019.

To contain spending after 2020, the report recommends setting a global target for federal health care spending and limiting its growth to the rate of increase in the GDP per capita plus 1 percentage point. If costs grow faster than the target, the Fiscal Commission's report recommends that the

President and Congress consider additional reforms to lower spending, such as developing a premium support system for Medicare, creating an all-payer system, or expanding the authority of the IPAB beyond Medicare.

Bipartisan Policy Center Proposal

The proposals advanced by the Bipartisan Policy Center's Debt Reduction Task Force aim to reduce federal spending through 2020 by \$2.7 trillion, including \$756 billion in savings from reduced health care spending.

The health care savings would come from phasing out the tax exclusion for employer-sponsored health insurance (saving \$113 billion); malpractice reforms, such as requiring states to cap awards for noneconomic and punitive damages (saving \$48 billion); and an excise tax on sweetened beverages (saving \$156 billion).

The task force's specific proposals for Medicare and Medicaid (with estimated savings through 2018) include:

- Raising the Medicare Part B premium from 25 percent to 35 percent of Part B costs over five years (savings of \$123 billion).
- Increasing rebates from drug companies under Medicare Part D (savings of \$100 billion).
- Redesigning Medicare cost-sharing (savings of \$14 billion).
- Bundling Medicare payment for acute and post-acute care (savings of \$5 billion).
- Eliminating barriers to enrollment for dual eligibles in managed care options (savings of \$5 billion).

Long-term savings are to be achieved by transitioning Medicare to a premium support option starting in 2018 (saving \$172 billion through 2020 and \$2.1 trillion through 2030) and at the same time reducing Medicaid cost growth to the rate of increase in the GDP per capita plus 1 percentage point (saving \$20 billion through 2020 and \$655 billion through 2030), which might be achieved in a variety of ways, including through a block grant from the federal government to the states.

Analysis of Deficit Reduction Proposals

There are some ideas worthy of serious consideration in these proposals, most importantly the longer-term recommendations in the Fiscal Commission report that build

upon Affordable Care Act provisions, including: expanding pilots of payment approaches that would shift the emphasis of our health care financing system from paying for piecework to rewarding coordinated, effective, and efficient care; reducing the wide and seemingly haphazard variation in health care prices to align the incentives they provide and make those incentives more consistent and powerful; and strengthening the ability to develop and implement policies that would control spending growth by expanding the scope of the Independent Payment Advisory Board.

However, our concern is that the focus of many of the other recommendations is mostly on reducing federal spending without consideration of the impact on beneficiaries, state governments, or businesses, rather than controlling health care spending overall. Achieving reductions in federal spending merely by increasing out-of-pocket costs to older, disabled, and chronically ill Americans through higher deductibles and coinsurance may save the federal government money, but it does not address the underlying causes of the rapid growth of health care costs—nor, for that matter, does it begin to address the problems faced by state and local governments, businesses, and families.

In many cases, these policies would create new financial barriers for the people who most need good health care, and thereby make the most appropriate care less accessible to them. As a result, people might avoid needed care or skip medications to manage their chronic conditions—and then end up in more expensive emergency departments or hospital rooms when they become too sick to avoid care any longer. Such policies do not control health care spending—they merely shift the costs to someone else's budget, including vulnerable retirees and the disabled.

The Bipartisan Policy Center suggests several options for controlling long-term growth in federal health outlays, including proposals to convert Medicare to a fixed-dollar voucher for the purchase of private insurance and turn Medicaid into a fixed-dollar block grant to the states. However, doing so would effectively abdicate the role of the federal government in controlling health care costs, and rely on private insurers or state governments to develop an effective cost-control strategy. This runs the risk that failure to control costs will result in fewer benefits and higher costs for Medicare and Medicaid beneficiaries who are least prepared to bear this burden.

So far, neither private insurers nor states have found a way to control health care costs. During the health care reform debate, private insurers effectively acknowledged that they could not control costs enough to compete against a public health insurance plan. Even large insurers often feel that they have to comply with demands for higher payment rates from major hospitals, physicians, and other providers, contributing to high and variable payment rates across providers. Only Medicare, as the largest purchaser of health care, has sufficient clout to set payment rates while still engaging the participation of nearly all providers.

Likewise, state governments already have wide discretion to control Medicaid spending by setting provider payment rates, contracting with private managed care plans, and establishing limits on the amount, scope, and duration of benefits. Yet, Medicaid is a comparatively small payer that is, in many states, chronically underfunded, and its beneficiaries are concentrated in low-income communities with a shortage of health care providers. As a result, low Medicaid payment rates have mostly had the effect of limiting an already sparse supply of participating providers. Converting Medicaid to a block grant would not increase the number of effective tools in states' cost-control toolkits.

The federal government is most capable of taking the lead in resetting incentives for providers and consumers by rewarding quality and high-value care and harmonizing public and private payment for medical services so that payment rates are more consistent across providers and patients and the incentives they present effectively reward better and more efficient care. Instead of focusing almost exclusively on reducing federal spending, the United States must reform its fragmented and misaligned financing system to get at the roots of rapidly growing health care costs in both the public and private sectors. Indeed, with public oversight and accountability, Medicare could act in concert or partnership with private insurers to address factors contributing to rising costs, leveraging the combined purchasing power of all payers to achieve value for money spent and slow the growth in health care costs.

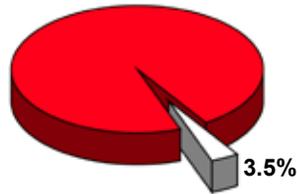
Finally, we should recognize that with reasonable economic growth we as a nation can afford to care for our seniors, ensuring their dignity and enjoyment of life in their older years. Professor Uwe Reinhardt of Princeton University estimates that GDP per capita will grow from \$40,000 in 2005

Exhibit 4. Medicare Spending and GDP, 2005 and 2050

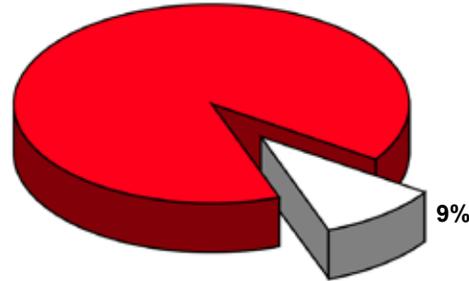
Assumes real (inflation-adjusted) GDP per capita grows at 1.5% per year

■ Medicare in GDP

■ Non-Medicare GDP left over



GDP per capita \$40,000
Medicare as percent of
GDP 3.5%
2005



GDP per capita \$73,000
Medicare as percent of
GDP 9%
2050

Source: Uwe Reinhardt, Ph.D., Professor, Princeton University.

to \$73,000 in 2050 in constant dollars. Even if Medicare spending increases from 3.5 percent of GDP in 2005, to 9 percent in 2050, there will still be major increases in economic resources available for other uses (Exhibit 4).

We can certainly afford to take the time to design sensible and effective solutions that achieve savings without sacrificing access to care for our nation's most vulnerable populations or undermining innovation and quality of care. Nor can we forget the need to restore federal tax revenues to work toward balancing the federal budget.

As the Fiscal Commission's report notes, the Affordable Care Act includes important provisions that will finally begin to control unchecked health care costs, such as the establishment of insurance exchanges that will reduce administrative overhead and new market rules such as standardized benefits, bundled payment pilots, and the creation of the Independent Payment Advisory Board. Building on and extending these provisions across the health system has the greatest promise of slowing the growth of government health care budget outlays, private insurance premiums, and underlying health care cost trends.