



Capping Federal Health Expenditures Does Not Reduce Costs – It Merely Shifts Them

While short-term growth in U.S. debt is primarily caused by the recession, concern is growing about rising long-term debt which is driven largely by projected growth in health care costs. Many potential solutions are under discussion in political and policy circles. Among the most troubling are proposals to cap federal health expenditures, such as the Commission on Fiscal Responsibility and Reform's suggestion to cap them at no more than 1 percent more per year than overall economic growth.

A cap on federal health expenditures shifts costs onto seniors and middle-class Americans. For 30 years, per-beneficiary spending in Medicare and Medicaid has grown at nearly identical rates to overall health system spending. Capping federal health spending does nothing to address the underlying cost increases in our nation's health care system. While it may reduce what people contribute in taxes to support Medicare and Medicaid, it does so by increasing what they pay in premiums and cost-sharing while undermining access to coverage and care.

Furthermore, since the cap is on *overall* spending not *per-beneficiary* spending, it fails to account for our aging baby-boomer population. As a more Americans qualify for Medicare and Medicaid, the cuts to federal health spending will need to be even more severe to stay within this cap. This could place severe financial hardships on:

- **Seniors** Medicare expenditures will quickly overrun the cap on federal health care spending, forcing significant cuts. Medicare beneficiaries – whose median income today is only about \$23,000 – will face higher cost-sharing requirements and skimpier benefit packages. Medicare benefits are already less generous than typical employer-sponsored insurance. Further cuts could reduce senior's access to needed health care services.
- **Middle-class Americans** The overall cap on federal health expenditures would also encompass the cost of the tax exclusion for employer-sponsored insurance, putting enormous pressure on policymakers to limit – beyond the limits the Affordable Care Act (ACA) already places – or eliminate this popular tax exemption. This would shift costs on to the majority of middle-income Americans who get their coverage through their employers. The federal cap would also undermine the tax credits that the ACA provides to low- and moderate-income Americans through the Exchange, jeopardizing the success of the new law.
- **State governments** As the federal government is forced to scale back its Medicaid spending in order to stay within the global cap, states will be left picking up a larger share of Medicaid costs, which will be hard to bear even in economic booms. In hard economic times the federal government has historically *increased* its Medicaid contributions to help states handle the rise in enrollment stemming from layoffs and poor economic performance; a global cap on federal expenditures will eliminate this successful tool for helping states weather economic downturns.
- **Other vulnerable Americans** Millions of low-income children and parents, people with disabilities, and seniors rely on Medicaid. But as the federal government cuts back its Medicaid spending, states will be forced to find savings by slashing enrollment, increasing cost-sharing requirements, and eliminating coverage for critical health services. All of these cuts will leave vulnerable Americans without access to the health care they need.

- **Health care providers** Faced with increased Medicaid costs, states will also likely to turn to provider rate cuts. Medicaid already reimburses less than Medicare and private insurance; even lower rates could force more providers to stop serving Medicaid patients and jeopardize the financial integrity of the provider safety-net system.

The ACA works to rein in health spending. A global cap doesn't address the root cause of soaring health care costs. On the other hand, the ACA implements several approaches that could put us on a path toward more sustainable health care, including:

- **Forcing tough Medicare spending cut decisions.** Starting in 2014, if Medicare *per beneficiary* spending growth exceeds a specified level, a new independent entity is charged with developing proposals to slow the growth of Medicare spending. The HHS Secretary is required to implement those savings proposals unless Congress adopts alternative proposals resulting in an equivalent level of savings.
- **Improving care coordination for the chronically ill.** The ACA targets the highest-cost enrollees – those with multiple chronic illnesses and those who are eligible for both Medicare and Medicaid – and explores new ways to improve their care coordination. For example, the law creates the Center for Medicare and Medicaid Innovation, responsible for designing and evaluating payment and delivery system models and expanding those that successfully reduce costs and improve quality. The ACA also creates a new Federal Coordinated Health Care Office with funding to assist states in better integrating care for this vulnerable population.
- **Investing in public health and primary care.** Seventy-five percent of our health care dollars are spent on chronic illnesses, many of which are preventable. The ACA makes a \$15 billion dollar investment in prevention in public health programs, like community-based initiatives, to reduce the incidence of chronic illness.
- **Keeping seniors out of costly institutional care.** Only 43 percent of Medicaid long-term care costs are spent on home- and community-based care. Not only do most seniors and people with disabilities prefer to stay at home, but it is often more cost-effective. The new law includes new incentives and tools for states to rebalance their long-term care towards home- and community-based services, and new supports to help Medicare beneficiaries stay out of institutional care.
- **Reducing or eliminating payments for preventable complications and readmissions.** The CDC estimates that hospital-acquired infections alone add as much as \$45 billion to hospital costs paid each year by taxpayers, insurers, and patients. The estimated cost of preventable re-hospitalizations nationwide is \$17 billion a year. The ACA requires HHS to determine some readmission rates of hospitals and to reduce Medicare payments to those with high readmission rates for patients with specific conditions. The law also extends to Medicaid the current restriction on Medicare payments to hospitals for hospital-acquired conditions.

It will take time to rein in health care costs. Congressmen concerned about the impact of health care expenditures on the federal deficit would be wise to give these initiatives the time and resources they need to be implemented, evaluate which are most effective, and help to expand them.

Key Takeaway: An arbitrary cap on federal health expenditures fails to address the underlying problem of rising health care costs, undermines health and financial security for seniors and other vulnerable populations, and shifts spending burdens onto states governments and health care providers. Congressional leaders serious about lowering federal health expenditures should advance the innovative attempts in the ACA to tackle the root causes of health spending increases.