COMMUNITY CATALYST

A Better Path to Solving the Debt Problem: Capping Federal Health Expenditures Misses the Mark

Concern is growing about projected rising long-term debt which is driven largely by anticipated growth in health care costs.[1] Many potential solutions to the debt problem are under discussion in political and policy circles.

Some have suggested that the way to deal with rising federal spending on health care is to make fundamental changes to public health insurance programs such as turning Medicare into a voucher for the purchase of private insurance and turning Medicaid into a capped federal block grant.[2] Others have been less direct, suggesting a global cap on federal health spending without indicating the mechanisms that will be used to keep within the budget.[3] In reality, there is little to choose from between the two approaches. An overall cap on federal health expenditures will almost inevitably lead to spending caps on Medicare and Medicaid and benefit cuts for beneficiaries.[4] The "global cap" is not actually health policy but rather is a device that obscures unpopular policy from public view. [5]

This paper:

- Summarizes why a cap on federal health spending would be harmful and also misses the mark in containing health care costs
- Reviews the many promising cost containment approaches have already been included in the Affordable Care Act (ACA)
- Outlines additional opportunities to contain public sector health costs
- Identifies an overall approach and several specific illustrative policy options that are less likely to harm the health care system, state governments, seniors, children, people with disabilities and other vulnerable constituencies than is the blunt instrument of capping federal health expenditures

A cap on federal health expenditures would harm seniors and other vulnerable populations

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 become aged or disabled and qualify for Medicare and Medicaid, the cuts to federal health spending will need to be ever 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 less than $20,000 – will face higher cost-sharing requirements and skimpier benefit packages.[6] Medicare benefits are already less generous than typical employer-sponsored insurance.[7] Further cuts could reduce seniors' access to needed health care services.[8]

- **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 limits already placed by the ACA – or eliminate this popular tax exemption. This would shift costs 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. 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 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.

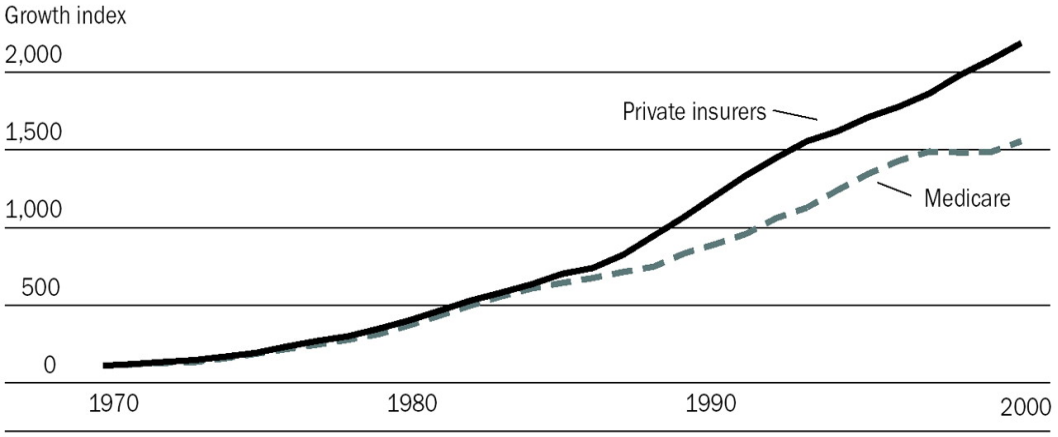
A cap on federal health expenditures fails to address the underlying problem: rising system-wide health care costs

Public health care spending is not a problem unto itself, but rather part of a larger trend: growing system-wide health care costs. A cap on federal health expenditures misses the mark by failing to address:

- The link between public and private insurance cost increases
- The link between the health status of the population and health expenditures
- The weaknesses of U.S. health care system; specifically
    - Lack of purchaser leverage relative to providers
    - Administrative waste
    - Unnecessary and avoidable spending on health services

Focusing solely on public sector health spending is a recipe for failure
National health expenditures have been rising faster than Gross Domestic Product overall for many years and are projected to continue to do so in the future.[9] It is this projected increase which accounts for the bulk of the long term U.S. debt problem. However, it is a mistake to focus exclusively on public sector health spending. The growth in per-beneficiary public sector spending has largely tracked private sector spending, actually growing at a slightly slower rate.[10]

Growth Rates: Private Insurers v. Medicare



SOURCE: Urban Institute analysis of National Health Accounts data from the Centers for Medicare and Medicaid Services.

If private sector spending growth is ignored, a growing differential between public and private payment rates will inevitably drag public spending upward. Indeed we have seen this dynamic at work with respect to physician payments and Medicare. Furthermore, it is the payment differential between Medicaid and private payers that is often cited as the reason for shortages of certain providers willing to take Medicaid. Finally, an ever-growing differential between public and private insurance rates and benefits is unlikely to be acceptable to seniors and their families as well as providers. An approach that tries to realize large federal health savings by decoupling federal health spending from private spending is likely to fail politically.[11]

Long term cost containment requires an improvement in population health
Seventy-five percent of our health care dollars are spent on chronic illnesses, many of which are preventable. And increases in the prevalence and treatment intensity for chronic diseases are responsible for about two-thirds of the increase in national health expenditures over the past 20 years.[12] If we could reduce obesity levels back to what they were in 1980, the health care system would save about $60 billion per year.[13]

A range of community-based prevention efforts have proven effective at reducing major contributors to chronic illness such as smoking, poor nutrition and insufficient physical activity. Research shows that an investment of $10 per person per year in these proven community-based

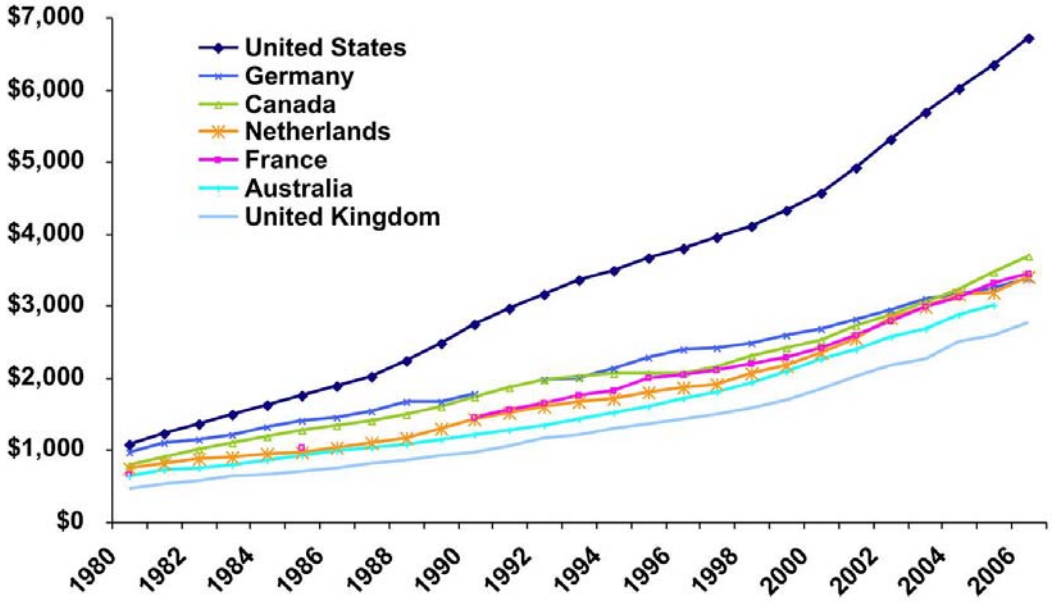
disease prevention programs could yield net savings of more than $2.8 billion annually in health care costs in one to two years, more than $16 billion within five years, and nearly $18 billion in 10 to 20 years.[14]

Efforts to reduce health spending should target specific weaknesses in the U.S. health care system

The U.S. spends more than other advanced countries even when adjusted for wealth, and even though we have a higher rate of uninsured, which tends to suppress health spending overall.[15]

International Comparison of Spending on Health, 1980–2006

Average spending on health per capita ($US PPP*)



* PPP = Purchasing Power Parity.
Data: OECD Health Data 2008, June 2008 version.

Not only is health care in the U.S. more expensive, but the rate of spending increase in U.S. is accelerating relative to other countries.[16] Despite this extra spending we do not have markedly better clinical outcomes.[17]

However, it is important to bear in mind that while health spending in the U.S. is roughly evenly divided between the public and private sector, the excess spending and the *sources* of excess spending are not evenly distributed. Compared to other countries, the U.S. pays much higher prices for medical services and has much higher administrative costs.[18] For example, the US pays and estimated excess of $98 billion per year due higher prices for prescription drugs and an excess of $91 billion per year in administration, two thirds of which is attributable to private insurance.[19]

However this is much less true for public insurance programs. Medicare and Medicaid pay lower rates and have lower administrative costs than private insurance.[20] This suggests that as currently constituted, the private insurance market in the U.S. is unable or unwilling to effectively contain

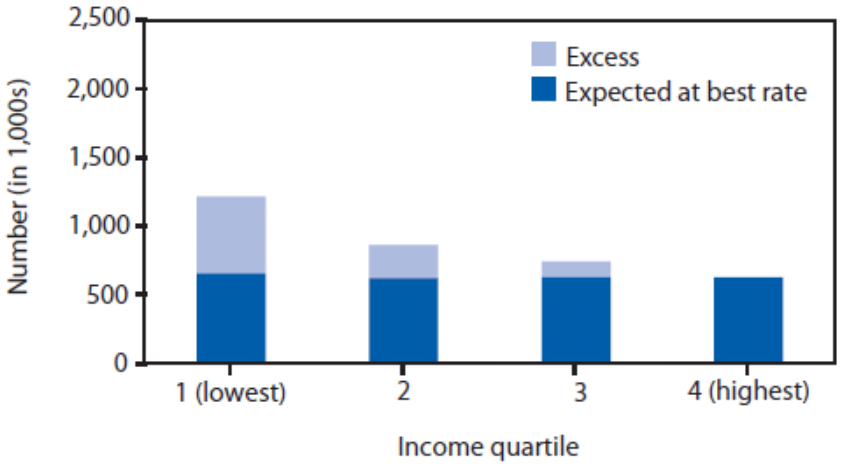
health care costs. It also suggests limited opportunities to reduce public sector spending by reducing administrative costs or rates.

As an alternative to administrative savings or rate reductions, another approach to containing public sector health care costs would be to reduce benefits for the elderly, people with disabilities and low-income Americans. However, only the most draconian approaches, such as imposing significant limits on hospital care, are likely to substantially reduce costs. More modest strategies, such as co-payment increases for prescription drugs or physician services are likely to produce only small reductions in spending or may actually increase spending because they would result in the substitution of higher cost services for those with lower costs.[21] As already noted above, this strategy would also impose substantial harm on American families, states and health care providers.

Although neither administrative savings nor rate cuts are promising approaches to reducing public sector health spending and draconian benefit reductions targeted at vulnerable populations should be unacceptable in the richest nation in the world, there are other options that will reduce public health care spending.

The third area of weakness in the U.S. health care system is unnecessary or avoidable spending on clinical care. Studies have suggested that a substantial portion of care delivered in the U.S. provides little or no clinical benefit.[22] It stands to reason that because the public insurance programs Medicare and Medicaid insure the sickest members of the population, this is also where the greatest clinical waste occurs as indicated by a number of studies. For example, the incidence of potentially preventable hospital admissions is much higher among people with the lowest income.[23]

Number of excess potentially preventable hospitalizations, by area income
Prevention Quality Indicators, United States, 2007



Source: Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2007.

Finally, payment errors and fraud remain a significant problem in public health insurance programs. According to a recent Government Accountability Office report, the Department of

Health and Human Services (HHS) estimates that payment errors of various types account for nearly 10 percent of all Medicare payments.[24]

Creating a structure to contain costs

Putting together what we know about the sources of excess spending and spending growth in the U.S., we conclude that a long term approach to public sector cost containment should rest on three pillars:

1. Reducing unnecessary spending and cost increases in public programs through
   a. payment reform
   b. delivery system reform
   c. payment integrity
2. Reducing the incidence of chronic illnesses that drive public health spending ranging from HIV and substance abuse to diabetes and heart disease
3. Blunt the upward pressure on public health insurance spending caused by ever-increasing private sector spending by:
   a. Reducing private sector administrative costs and limiting excess payments
   b. Strengthening private sector payers' abilities to negotiate with providers

It is notable, that all three of these approaches are embodied in the ACA. For example the ACA includes payment and delivery system reforms such as:

- **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 equivalent 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.

- **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 Centers for Disease Control and Prevention 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 per 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.

- **Reducing payment errors.** The ACA includes a series of provisions to fight fraud and improve the payment integrity of public insurance programs including stepped up provider checks, enhanced resources for fraud prevention and enhanced overpayment recovery efforts.[25]

- **Expanding the primary care workforce**. The ACA invests heavily in the primary care workforce, so illnesses can be diagnosed and treated early. It injects $11 billion into Community Health Centers over the next five years, enabling them to nearly double the number of patients they are able to serve. It also significantly increases reimbursements for primary care services under Medicare and Medicaid, and expands loan repayments and scholarships for the primary care workforce.

The ACA also makes a long term commitment to improving the health of Americans.

- 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.

Finally, the ACA creates stronger tools to hold down premium increases in the private sector including:

- creating health insurance Exchanges to facilitate “apples to apples” comparisons of health insurance options,
- increasing state resources and authority to review premium rate increases,
- setting minimum Medical Loss Ratios to hold down insurance administrative costs.

In addition, the excise tax on high cost health plans and the Basic Health Plan option and state flexibility waivers create financial incentives and opportunities to hold down costs.

More can and should be done.

It will take time for the initiatives to begin reining in health care costs. We need to give the various efforts advanced in the ACA the time and resources they need to be implemented, evaluate which are most effective, and help to expand them. Beyond implementing and expanding the cost-control mechanisms in the ACA, more can be done to reduce federal health expenditures, consistent with the framework outlined above. A few illustrative examples, though by no means an exhaustive list, include:

Reducing excessive health spending by:

- **Helping generic drugs make it to the market faster**: Federal Trade Commission reports document that the drug industry has increasingly delayed access to generic drugs by paying off competing generic manufacturers, forcing Centers for Medicare and Medicaid Services to pay billions more for brand-name drugs through Medicaid and Medicare. As the Administration has proposed in its 2012 budget, banning these pay-for-delay settlements would reduce federal Medicare and Medicaid expenditures by nearly $9 billion over a 10 year period.[26]

  Congress can also speed up generic market entrance by shortening the period of exclusivity for brand-name biologic drugs. Biologic drugs can cost hundreds of thousands of dollars a year for a single patient. Some classes of biologic drugs to treat Multiple Sclerosis or other disorders have seen alarming price increases of 20 percent or more in the last two years. If Congress shortened the period of exclusivity for brand-name biologic drugs from 12 years to seven years, as the Administration proposed in its 2012 budget, Medicare and Medicaid costs would drop by more than $2 billion over a 10 year period.[27]

- **Requiring drug companies to pay the Medicaid rebate for dual-eligibles:** The Medicaid Drug Rebate Program requires drug manufacturers to offer rebates to state governments for prescription drugs purchased for Medicaid beneficiaries. This rebate program, however, does not apply to dual-eligibles (Medicare recipients who are poor enough to also qualify for Medicaid). When the Senate Finance Committee considered an amendment to the ACA that would require drug manufacturers to pay Medicaid drug rebates to the federal government for drugs provided to dual-eligibles during the ACA debate, the Congressional Budget Office (CBO) estimated that this would save the federal government $106 billion over 10 years.[28]

- **Providing stronger incentives for hospitals to reduce preventable complications and readmissions in Medicare and Medicaid:** While the ACA extends to Medicaid the current restriction on Medicare payments to hospitals for hospital-acquired conditions, Congress could go further to move Medicare and Medicaid in the direction of paying for outcomes instead of for volume. In particular, the federal government could take a more comprehensive approach to reducing potentially preventable conditions for Medicare beneficiaries and work with states to transition to Medicaid payment methodologies that reduce payments for preventable readmissions and a broader array of preventable complications.[29]

- **Introducing a meaningful public health insurance option:** A public option would have lower administrative costs, and – assuming it had the right negotiating or rate-setting authority – lower provider payment rates than most private health insurance plans, placing competitive pressure on private plans to lower their own costs. By reducing premiums in the Exchange, a public option could reduce the cost of providing premium tax credits to low- and moderate-income families in 2014 and beyond. Recently, the CBO

estimated that a national public option would generate $88 billion in savings over 10 years.[30] In addition to holding down the cost of premium subsidies, by exerting downward pressure on private insurance premiums a public option would also help yield indirect long term health care savings. While adding a public option at the national level does not seem politically feasible at this time, it merits serious consideration rather than proposals that would inevitably lead to fewer benefits, higher costs and worse outcomes for the poorest and sickest members of society.

- **Taxing sugar sweetened beverages**: Over the long run, a healthier population is one of the keys to moderating health spending growth. Taxing sugar sweetened beverages would be a good place to start. It would have the double benefit of reducing obesity (especially childhood obesity)—a major contributor to higher health costs—and raising revenue to help balance the budget.

Unfortunately, the main caveat with these ideas is that most of them were considered in some form during the debate over the ACA and were not adopted. If anything, the political environment today is less propitious than it was then. However, if the alternative is to remove fundamental guarantees of coverage from Medicare and Medicaid beneficiaries and shift costs onto seniors, people with disabilities, families with children, providers and state and local governments, then ideas that were rejected during the ACA debate deserve a second look. They are less radical and less harmful than stripping Medicare and Medicaid beneficiaries of their benefits and they have the additional virtue of actually addressing the causes of high health care costs in the U.S.

Conclusion

Controlling health care spending over the long run is a critical component of securing our financial future. However, a narrow focus only on federal health spending is likely to cause serious harm to Medicare and Medicaid beneficiaries and their families, and to put tremendous financial pressure on states and providers. It also misses the mark by failing to focus on the causes of excess health spending and spending growth in the U.S. Instead, policies aimed directly at reducing clinically unnecessary or avoidable spending in public insurance programs; improving the underlying health status of the American people; and holding down the growth rate of private sector cost by improving administrative efficiency and creating stronger purchasers are all likely to yield substantial cost savings going forward.

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[1] http://www.cbo.gov/ftpdocs/115xx/doc11579/Summary_LTBO.pdf
[2] http://bipartisanpolicy.org/sites/default/files/FINAL%20DRTF%20EXECUTIVE%20SUMMARY_0.pdf
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