Do the Right Thing:

How Congress Can Generate Health Care Budget Savings Without Hurting Medicare and Medicaid Beneficiaries

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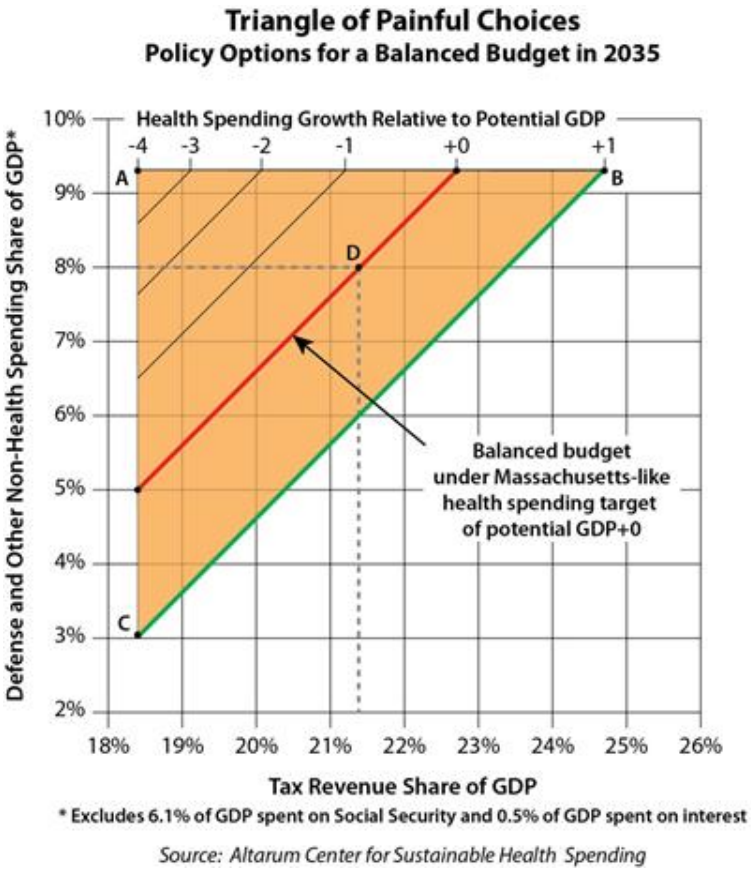
Table of Contents

Introduction

Reducing the projected long-term national debt is the central focus of policymakers from both parties as we move into President Obama's second term in office. Health care cost containment plays a prominent role in the debate because rising health care costs are seen as a primary driver of the debt. As former Director of the Office of Management and Budget (OMB) Peter Orszag wrote in a recent Institute of Medicine (IOM) report, "Put simply, if we do not act to address rising health care costs, anything else we do to reduce long-term federal deficits will be for naught."[1]

Achieving long-term budget balance without bending the health care cost curve would require both historically high revenues and unacceptable cuts in everything else government does. The Altarum Center for Sustainable Health Spending has calculated that even if we were to reduce federal health spending growth to the rate of potential gross domestic product (GDP) growth and maintain other federal spending at historical averages, then federal tax collections would have to rise to the historically high level of more than 22 percent of GDP to balance the budget by 2035.[2]

The question therefore is not whether we need to reduce health care spending, but rather how we should go about it. There are two contrasting ways of defining the health care cost problem, which in turn give rise to starkly different solutions.



Source: Altarum Center for Sustainable Health Spending

One approach looks at the problem solely in terms of federal spending. From this perspective, solutions that shift costs to other parts of the health care system, including state governments, employers, privately insured individuals and Medicare and Medicaid beneficiaries are perfectly acceptable. Examples of this approach include proposals to convert the federal share of Medicaid financing into a block grant or per capita cap,[3] [4] to transform Medicare into a premium support program, [5] and to raise the Medicare eligibility age from 65 to 67 years.[6]

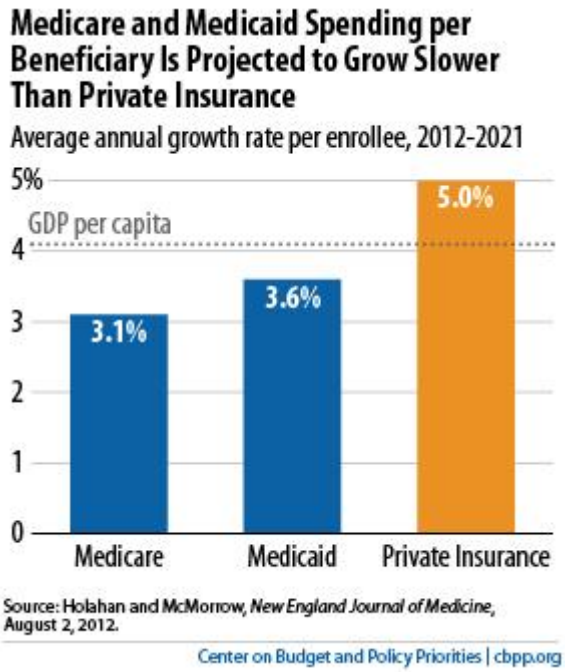
Unfortunately, this type of approach is disconnected from the true causes of excessive health spending and would cause serious harm to many people. These proposals are analogous to trying to lose weight by amputating a limb.

An alternative view looks at the underlying causes of high health care costs and identifies strategies to address these causes. Taking this view, Community Catalyst has developed a cost-containment agenda that directly tackles the underlying causes of rising health care costs: structural weaknesses in the financing and delivery of health care in the United States, and the underlying health status of the American people, such as rising rates of obesity.

Below, we offer a brief critique of the cost-shifting approach to cost containment. We go on to identify specific drivers of high health spending related to poor quality, high prices and poor population health, and propose reforms that would produce more than $700 billion in health care savings and health care-related revenues, while protecting consumers, maintaining coverage and improving health care quality.[7] While this paper is focused mainly on reducing the federal debt in the short term, we recognize that in the long term a more comprehensive approach that also slows the rate of growth in private health spending will be necessary for ultimate success.[8]

Cost shifting is not the answer

Reducing Medicare and Medicaid benefits cannot produce meaningful savings without harming beneficiaries. These programs are already lean and responding to aggressive state and federal cost containment efforts. Projected growth in Medicare and Medicaid spending per enrollee is less than projected growth in private insurance spending per capita, and in recent years has grown more slowly than the overall economy. Further efforts to constrain spending growth must therefore be targeted to avoid unintended adverse effects.[9]



Shifting costs onto Medicare beneficiaries will excessively burden sick patients with only modest resources

Medicare is already less generous than private insurance.[10] Many Medicare beneficiaries have very modest incomes and are already contributing substantially to the costs of their care. In 2010, the average Medicare beneficiary had an income of less than $22,000, [11] and contributed 17 percent of this income toward their health care.[12] The sickest beneficiaries contribute more than one-third of median income to their care. Since Medicare spending is highly concentrated among the sickest enrollees, increasing Medicare cost-sharing will mainly increase the financial burden on the sickest population without substantially reducing costs.[13]

Proposals to increase the Medicare eligibility age are emblematic of the short-sighted cost shifting approach to reducing federal health spending. While federal health spending would be reduced, costs would be higher for employers (who would have to pay to keep older adult employees on their health plans longer), states (who would have to pay to keep low-income older adults on Medicaid longer) and individuals (who would have to continue paying for private insurance longer). Additionally, overall health spending would increase, since private insurance costs more per capita than Medicare.[14]

Neither states nor Medicaid beneficiaries are an appropriate target for federal cost shifting

Cost-shifting onto Medicaid is even more problematic. Medicaid is already a very lean program that typically pays lower rates for health care services than private insurance or Medicare.[15] Most beneficiaries are poor, and therefore cannot contribute meaningfully to the cost of their care. Reduced federal funding for Medicaid would likely force states to further cut already low provider payments and place additional strain on state budgets.

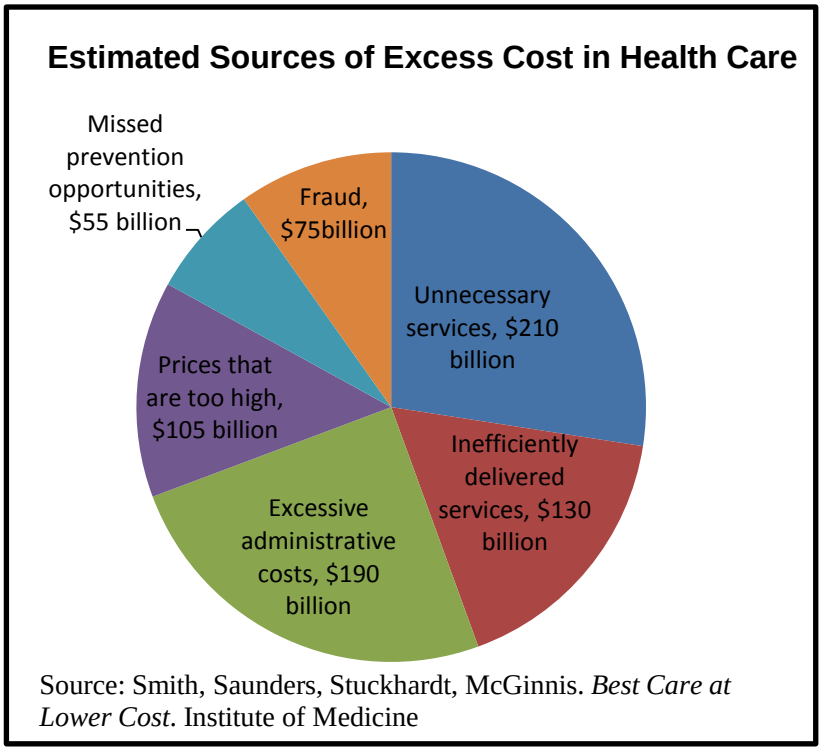
In addition to the negative impact on beneficiaries, safety-net providers and state budgets, federal cost-shifting onto state Medicaid programs is also likely to impede the expansion of Medicaid to

all people below 133 percent of the federal poverty line (FPL), as envisioned by the Affordable Care Act (ACA). Now that the Supreme Court has eliminated any federal sanctions for failure to expand Medicaid, reduction in federal support would be a disincentive for states to take up the expansion. This jeopardizes coverage for up to 15 million low-income adults who are expected to enroll in Medicaid through the ACA.

An alternative to cost shifting starts by exploring the reasons why health care spending is so high in the United States.

Identifying the real culprits behind high U.S. health care spending

The United States spends more on health care than any other country, but it doesn't necessarily get its money's worth. Even after adjusting for income, U.S. spending on health care is much higher than in other countries.[16]



Source: Smith, Saunders, Stuckhardt, McGinnis. *Best Care at Lower Cost*. Institute of Medicine

A large body of evidence suggests Americans are not getting what they pay for. For example: a recent IOM report found the U.S. health care system wastes approximately $750 billion annually. The main sources of this waste are excessive administrative costs, excessive prices for services and, broadly speaking, poor quality of care.

Furthermore, the U.S. health care system performs significantly worse than other high-income countries on those measures of premature death which the health care system has control over. In one recent study, investigators found the United States had the highest rates of health care amenable mortality among 16 wealthy countries in 1997-1998 and the least amount of progress by 2006-2007.[17]

Excessive prices are a significant part of the problem.
Americans pay higher prices for health care services than their Organization for Economic Co-operation and Development (OECD) counterparts.[18] In one famous comparison of health care spending in the U.S. and OECD countries, authors even titled their article: "It's the Prices, Stupid."[19] In 2011, excess prices caused an estimated $84 billion to $178 billion in unnecessary health care spending.[20] While most of the excess prices are found within the private sector, researchers have identified a number of areas where prices paid by federal health programs are excessive, particularly with regard to prescription drugs prices and rates paid to Medicare Advantage plans.

Unnecessary and low-quality care drives up costs.
Spending on health care services that fail to contribute to positive health outcomes (or may even harm patients) is another significant source of waste in the system. As much as 30 percent of health care spending is waste of this type.

Using Medicare data, researchers at Dartmouth College found the quality of care is not measurably better in regions of the country that spend more on health care, even though these variations in spending cannot be explained by the relative health or socioeconomic status of the patient populations.[21]

One cause for high costs and low quality are preventable events, including readmissions and complications. In 2007, the Medicare Payment Advisory Commission (MedPAC) estimated preventable readmissions result in $15 billion in excess Medicare spending every year.[22] Potentially preventable complications, such as infections in surgical sites, urinary tract infections from catheters or patients contracting pneumonia after being admitted account for 9 percent of all Medicare inpatient spending.[23]

Another problem is a lack of primary care. Recent analysis by Harvard University economists found higher spending regions had lower overall quality of care than lower spending regions. The authors also found regions with high concentrations of specialists tended to spend more. They conclude an imbalance between primary care providers and specialists may be a key driver of both higher costs and lower quality.[24]

Poor and declining underlying health status leads to avoidable spending

Rising obesity rates and associated health conditions drive up health care spending. Adult obesity rates have doubled over the past thirty years[25], while childhood obesity rates have tripled.[26] Obesity increases the risk of conditions such as heart disease, diabetes and cancer, among others. According to recent estimates, obesity-related medical costs account for nearly 21 percent of total health care spending in the United States.[27]

Tobacco use also remains a high source of preventable health care spending. Tobacco use remains the leading cause of preventable death and disease in the United States.[28] Cigarette smoking causes approximately 443,000 deaths each year[29], as well as nearly $200 billion in health care costs ($96 billion) and productivity losses ($97 billion).[30] While youth tobacco use declined significantly from 2000 to 2011, tobacco use among middle school students stagnated from 2009 to 2011. Public health strategies are necessary to protect our gains in tobacco prevention and reduce tobacco-related health care costs.

Alcohol abuse also drives health care costs. According to the Centers for Disease Control, alcohol imposes more than $200 billion per year in costs on society. While most of this cost is due to lost productivity, direct health care costs of alcohol abuse still account for more than $10 billion per year.[31]

Congress could achieve more than $700 billion in health care savings and revenues by attacking the real drivers of high and rising costs

Reviewing the drivers of health care spending in the United States highlights key opportunities to control health care spending in a systematic way. These opportunities can be grouped under three strategies:

I. Improve quality
II. Reduce excessive payment rates
III. Improve the public's health

The health care cost-containment agenda below reduces excessive prices, weeds out low-value care, and improves the underlying health status of the American people. It would reduce the federal debt by $721 billion over ten years. Importantly, all of the proposals included in this agenda either already exist in legislative form or could easily be converted into legislation, and have been or could be scored by the Congressional Budget Office (CBO).

I. Improve quality

Reducing hospital payments for potentially preventable complications and potentially avoidable readmissions

Estimated savings: $50 billion

Medicare should reduce payments to hospitals with higher-than-average preventable complication rates. Each hospital's payment reductions would be based on the estimated cost of that hospital's "excess" complications, when compared to the average cost of excess complications. Similarly, Medicare should also reduce payments to hospitals with higher-than-average rates of potentially avoidable readmissions. Rates would be risk-adjusted to avoid penalizing hospitals that treat sicker patients. Based on the available literature, these reforms would produce in the vicinity of $50 billion in savings over 10 years.[32]

In addition MedPAC has recently estimated that as many as 25 percent of initial admissions and almost 60 percent of ambulatory emergency room visits are potentially preventable, suggesting there is ample room for additional savings if delivery system reforms successfully create "accountable" care bodies that integrate hospital and ambulatory care. [33]

Investments in primary care can improve quality and decrease costs

Estimated Savings: Up to $150 billion[34]

The Affordable Care Act included a temporary 10 percent increase in Medicare reimbursement rates for primary care. Researchers in a study published by The Commonwealth Fund projected that a permanent increase would **reduce non-drug Medicare spending by 2 percent over ten years.**[35] Other evidence from various types of primary care initiatives that have resulted in improved quality and reduced costs, such as patient-centered medical homes (PCMH), indicates boosting primary care can lead to savings.[36] For example a Medicaid-sponsored PCMH in North Carolina decreased asthma-related hospitalizations by 40 percent and reduced emergency

department visits by 16 percent, resulting in total savings of $974.5 million over five years.[37] A Veterans Administration-sponsored PCMH intervention for chronic disease patients with chronic obstructive pulmonary disease reduced emergency department visits and hospitalizations by 41 percent[38], and resulted in $593 in savings per patient as well as reduced mortality.[39]

Subtotal estimated savings: $50 billion

II. Reduce overpayments

Cut Medicare Advantage overpayments

Estimated savings $30 billion

Researchers have consistently found Medicare has paid private managed care plans in the Medicare Advantage program rates in excess of what it would cost to cover beneficiaries through traditional Medicare.[40] Although the ACA reduced overpayments to Medicare Advantage plans, a recent analysis by the Urban Institute found on average plans were still being overpaid by 7 percent. A change in the payment formula to limit plan payments to 95 percent of the cost of traditional Medicare in high-cost counties and 100 percent in low-cost counties would largely eliminate this problem and save an estimated $30 billion in federal spending over 10 years.[41]

Purchase drugs more efficiently through Medicare Part D

Estimated Savings: $50 billion

Medicare Part D does not allow the federal government to negotiate price limits for prescription drugs. Although in the past CBO has not scored savings for drug price negotiation, this is largely because the proposals being scored did not allow Medicare to exclude over-priced drugs from its formulary or limit payments to a "reference price" for a comparably effective drug in the same class. According to an analysis by the National Committee to Preserve Social Security and Medicare (NCPSSM), if Medicare were allowed to set upper payment limits for prescription drugs while still allowing insurers to negotiate prices below that level, the federal government would save $200 billion over 10 years.[42] A second study published in the *Journal of General Internal Medicine* also supports the conclusion that savings could be achieved through drug price negotiation with the amount of savings dependent on how aggressively the Department of Health and Human Services (HHS) implemented the policy.[43] At the high end, this study yielded estimates essentially in line with the NCPSSM estimate. Using much more conservative assumptions would yield closer to $15 billion over 10 years. Our estimate of $50 billion is a middle-ground conservative estimate, assuming savings of roughly half the difference between current prices and the FSS and excluding low-income beneficiaries from the calculation to avoid double counting with the next proposal.

Eliminate the Windfall Profit to drug companies that was created by Medicare Part D

Estimated Savings: $135 Billion

Prior to the implementation of Medicare Part D, drug companies had to pay a significant rebate on drugs sold to beneficiaries eligible for both Medicare and Medicaid. The Medicare Modernization Act eliminated the rebate requirement. Extending the Medicaid drug rebate to low-income Medicare beneficiaries would save the federal government $100-$135 billion over 10 years, depending on the structure of the reform.[44]

Ban anticompetitive "pay-for-delay" settlements in which brand name drug companies pay potential generic competitors to stay out of the market

Estimated Savings: $11 billion

President Obama's 2013 budget proposal would ban pay-for-delay settlements and result in federal savings of $11 billion in ten years.[45] Pay-for-delay settlements are agreements between a brand-name drugmaker and a generic drugmaker in which the brand-name company pays the generic company to delay bringing a generic drug to market. A ban on these types of agreements would improve patient access to necessary pharmaceuticals while lowering health care costs. Federal Trade Commission Chairman Jon Leibowitz says banning pay for delay will "reduce the deficit by billions of dollars without raising taxes or cutting critical programs."

Reduce exclusivity period for brand-name biologics from 12 to 5 years

Estimated savings: $4 billion

More than 40 percent of the Medicare Part D budget is spent on the top six biologic drugs. On average, these drugs cost 22 times as much as traditional drugs. President Obama's 2013 budget proposal modifies the exclusivity period for brand-name biologics from 12 to seven years and results in federal savings of $4 billion over 10 years.[46] Reducing the exclusivity period to five years would generate even more savings. This proposal fairly balances incentives for innovation with the need for competition. The modification would increase access to cheaper generic drugs by allowing faster development.

Change payments to post-acute providers

Estimated savings: $57 billion

In their 2011 report to Congress, MedPAC identified a number of problems with payment to post-acute providers including increasing payments relative to costs and high positive margins for certain types of providers. MedPAC recommended adjustments to how payments are calculated for post-acute providers to reduce overpayments. [47] These recommendations were included in the President's FY 2013 budget and are projected to save about $57 billion over 10 years.[48]

Create a public option similar to Medicare that would compete with private plans in health insurance Exchanges

Estimated savings: $90 billion

The public supported a public health insurance option to compete with private insurers in health insurance Exchanges throughout the ACA debate.[49] More recently, the co-chairs of the National Commission on Fiscal Responsibility and Reform, otherwise known as the Bowles-Simpson debt reduction group, floated the idea of incorporating a public option into the Exchange if federal health spending growth exceeded GDP+1%.[50] The CBO estimated a public option would save nearly $90 billion over ten years largely through reducing the prices a public plan would pay to providers.[51]

Subtotal estimated savings: $377 billion

III. Improve the public's health

Reduce obesity rates by taxing sugar-sweetened beverages

Estimated revenue: $147 billion

Consumption of sugar-sweetened beverages is inextricably linked to childhood obesity. A national excise-tax of one penny per ounce, indexed for inflation, would both decrease consumption and raise revenues. An excise tax would reduce consumption by approximately 24 percent,[52] helping to reduce childhood obesity. Over ten years, the proposal would raise approximately $130 billion in revenue and reduce health care costs by $17 billion.[53]

Increase the federal excise tax on cigarettes

Estimated revenue and savings: $42 billion

Increasing the federal excise tax on cigarettes by 50 cents (a 10 percent increase, on average, nationwide) would raise approximately $41 billion in revenue from 2013 through 2021. The policy would reduce net Medicare and Medicaid spending by approximately $814 million over the same period because enrollees would be healthier on average.[54]

Equalize taxes on other tobacco products

Estimated revenue: $4 billion

Cigarette taxes have been an effective tool to reduce cigarette consumption. However, as federal, state and local governments have raised cigarette taxes, other tobacco products – such as cigars and smokeless tobacco – have often been left out. The relative price of other tobacco products has therefore dropped, and manufacturers and consumers have substituted cigarettes for these less expensive products.[55] While total cigarette consumption decreased by nearly a third between 2000 and 2011, these gains were partially offset by increased consumption of non-cigarette combustible products (e.g. cigars).[56] Equalizing taxes on other tobacco products would increase federal revenue by approximately $4 billion over the next five years.[57]

Reduce alcohol consumption by updating and equalizing the excise tax on alcohol

Estimated Revenue: $101 billion

Increasing the alcohol tax would reduce consumption for all drinkers, particularly the young, and help pay for the societal costs of alcohol abuse. Congress has not updated the federal excise tax on alcohol in more than 20 years. The value of the tax, and therefore its effectiveness, has eroded over time because it is not indexed for inflation. In addition, the tax rate varies by category of alcohol (i.e. hard liquor, wine and beer), which creates distorted incentives for consumers. Updating the tax to 1991 levels (the last time it was changed), indexing it for inflation, and equalizing the tax across alcohol categories would generate approximately $101 billion in revenue over 10 years.[58]

Subtotal estimated savings: $294 billion

Total estimated Savings: $721 billion

Conclusion

As federal debt reduction talks continue in the coming year, reducing federal health care spending will assume an important role in the debate. Policymakers face a choice: they can look at the problem solely in terms of federal health care spending or view high and rising health care spending as a result of systemic inefficiencies in the financing and delivery of health care in the United States and rising rates of obesity and other preventable conditions. Targeting the real drivers of high and rising health care costs will be essential to controlling overall health care spending while maintaining benefits and improving care.

The reforms detailed in this paper improve quality, reduce waste and improve population health while producing more than $700 billion in savings and revenue to decrease the federal debt. Importantly, all of these proposals have been, or can be, converted easily into legislative language and have been, or could be, scored by the CBO.

The critical question then is not whether we can reduce health care spending and reduce the federal debt while protecting vulnerable populations, but whether we have the political will to do so.

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Appendix A
Health Care Cost Containment: Getting It Right

Core principles	• Target real cost drivers • Avoid cost-shifting and unnecessary harm to patients, providers or state government		
Key approaches	Reduce low value public spending	Improve population health	Focus on private **and** public sector cost containment
Problem addressed	Expensive care that is avoidable or unnecessary and improper payments drive public health insurance spending	The deteriorating health status of Americans must be addressed in the long run for cost containment efforts to succeed	High prices and administrative costs lead to higher U.S. health spending without adding value
How to do it	• Payment reform • Delivery reform • Payment integrity	• Target conditions with strong connection to public health spending (e.g. HIV, low birth weight, obesity, smoking)	• Create stronger purchasers • Reduce administrative waste
Examples of what the ACA already does	• Eliminate MA overpayments • Improve payment integrity • Limit Medicare and ACA subsidy growth per beneficiary to GDP +1% • Change Medicare payment to incentivize good outcomes and avoid preventable admissions • Implement discharge transition program • Expand primary care in low-income communities • Encourage new payment and delivery models	• Prevention Fund • Childhood Obesity Demonstration Program	• Exchange • Medical Loss Ratio • Rate review

Examples of what more can be done

- Medicaid payment reform—reduce potentially avoidable events
- Additional Rx savings:
  - ◊ Medicaid rebate for duals
  - ◊ Medicare price negotiation (strong version)
  - ◊ Ban "pay for delay"
  - ◊ Speed biologics

- Sugar sweetened beverage tax
- Tobacco tax
- Alcohol tax

- Expand primary care supply / modify GME
- Realign responsibilities and rewards for effective cost containment in Exchanges
- Create a low-cost insurance option in Exchanges

Appendix B: Summary of Proposed Savings

Category	Proposal	Estimated Savings and Revenue
1. Improve Quality		
	Reducing hospital payments for potentially preventable complications and potentially avoidable readmissions	$50 billion
	Investments in primary care can improve quality and decrease costs	Up to $150 billion*
2. Reduce Excessive Payment Rates		
	Cut Medicare Advantage overpayments	$30 billion
	Purchase drugs more efficiently through Medicare Part D	$50 billion
	Eliminate the Windfall Profit to drug companies that was created by Medicare Part D	$135 billion
	Ban anticompetitive "pay-for-delay" settlements	$11 billion
	Reduce exclusivity period for brand-name biologics from 12 to 5 years	$4 billion
	Change payments to post-acute providers	$57 billion
	Create a public option similar to Medicare that would compete with private plans in health insurance Exchanges	$90 billion
3. Improved the Public's Health		
	Reduce obesity rates by taxing sugar-sweetened beverages	$147 billion
	Increase the federal excise tax on cigarettes	$42 billion
	Equalize taxes on other tobacco products	$4 billion
	Reduce alcohol consumption by updating and equalizing the excise tax on alcohol	$101 billion
Total		**$721 billion**

*Note, the source of savings is the net effect of increased spending on primary care minus the savings for reduced use of other types of care. The savings are not included in the overall total because of uncertainty about CBO scoring on this proposal and to ensure our estimated savings are conservative.

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