THE COMMITTEE FOR A
RESPONSIBLE FEDERAL BUDGET

HEALTH CARE WORKING PAPER SERIES:

Options for Controlling Federal Health Care Costs

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The Committee for a Responsible Federal Budget

About

The Committee for a Responsible Federal Budget

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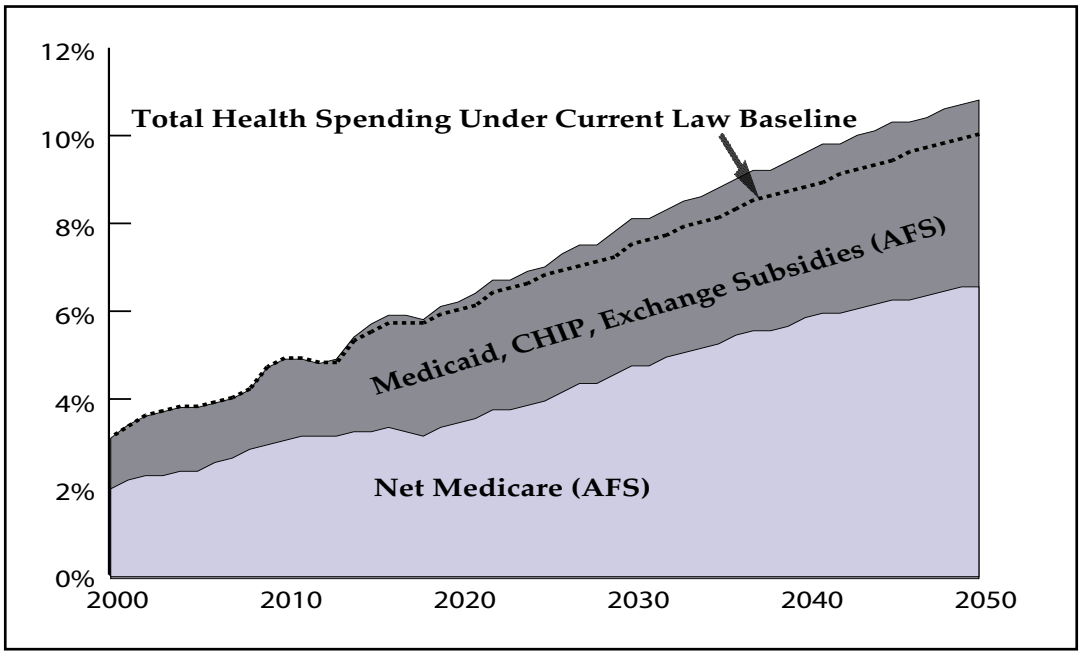
Options for Controlling Federal Health Care Costs

The growth of federal health spending represents the single largest fiscal challenge facing the United States government. In fiscal year 2012, total federal spending on health care approached $750 billion, which represents 4.9 percent of GDP and one fifth of the federal budget. By 2022, the Congressional Budget Office (CBO) estimates this number will increase to above $1.6 trillion or 6.7 percent of GDP and could continue to grow to nearly 9 percent of GDP by 2035 and 11 percent by 2050.

FIG 1. Federal Health Care Spending (Percent of GDP)



Note: Shaded portions of graph reflect spending as projected under CBO's Alternative Fiscal Scenario, which assumes annual doc fixes and certain cost controls from the Affordable Care Act are not in effect after 2022.

Even under CBO's current law projections, in which they assume politicians no longer pass "doc fixes" to prevent a 27 percent cut in physician payments and the cost controls in Patient Protection and Affordable Care Act (PPACA) are relatively successful, total health costs will grow to 8.2 percent of GDP in 2035 and 10.1 percent by 2050. By 2087, according to CBO, costs could grow to anywhere from 13.8 percent to 15.1 percent of GDP.

The growth of federal health costs is largely the result of two factors – population aging and per capita health care cost growth. The CBO finds that excess cost growth, the amount by which per capita health costs grow faster than the economy, will be responsible for 40 to 50 percent of the growth of Medicare and Medicaid over the next quarter century and more over the very long run. The remainder of cost growth is due to the retirement of the baby boom population, combined with continued gains in life expectancy.

FIG 2. Health Savings in the Simpson-Bowles Fiscal Commission Plan

One potential starting point for health savings could be the work of the Simpson-Bowles Fiscal Commission, which combined a number of short-term saving policies with a long-term process to require further changes. The Fiscal Commission proposed roughly $485 billion* in health savings through 2021 – including changes to cost-sharing rules, reduced payments to hospitals, new Medicare Part D drug rebates, medical malpractice reform, restrictions on states using their tax code to inflate their federal Medicaid matching rate, and numerous other policies.

Health Policy	Savings Through FY2021*
Savers	
Accelerate Home Health Cuts in Affordable Care Act	$10 billion
Limit States from Financing Medicaid Costs through Provider Tax	$50 billion
Apply Medicaid Drug Rebates to Dual Eligibles	$55 billion
Phase out Medicare Payments for Bad Debts	$30 billion
Reduce Subsidies for Graduate Medical Education	$70 billion
Reform Sustainable Growth Rate+	$35 billion
Reduce Fraud and Administrative Costs	$10 billion
Curve Benders	
Reform Cost Sharing Rules with Uniform Deductible, Unified Coinsurance, and Out of Pocket Limit for Medicare Part A and B; Restrict Medigap First-Dollar Coverage	$125 billion
Put Dual Eligibles in Medicaid Managed Care	$15 billion
Enact Malpractice Reform	$20 billion
Restrict TRICARE for Life First-Dollar Coverage	$45 billion
Give CMS Authority to Expand Pilot and Demonstration Projects	N/A
Fundamental Reforms	
Pilot Premium Support in FEHB Program	$20 billion
Allow Expedited Medicaid Waivers in Well-Qualified States	N/A
Eliminate Provider Carve-Outs from IPAB	N/A
Put Federal Health Commitments on a Budget with GDP+1% Growth Limit	N/A
Total Savings	**$485 billion**

*Note: Savings estimates rounded from June 2011, and are likely lower due to changes in the baseline.

+SGR policy called for the creation of a new formula based on quality of care, which could be classified as a "bender".

Though its proposals would make an important and substantial dent in federal health spending, savings proposed by the Fiscal Commission are not projected to be large enough to meet its long-term goal of slowing the total annual growth of health commitments to the rate of GDP plus one percent. Some of the payment reforms and other changes from the Commission's recommendations could very well exceed expectations; however, it may be wise to pursue additional savings beyond these recommendations in order to further control federal health spending.

Regardless of the causes, policymakers must act to slow health care cost growth over the next decade and importantly over the long-term. Substantial work is still needed to develop the policies that can truly slow the growth of federal health spending in a fair and efficient manner. Fortunately, numerous policy proposals already exist that can begin the process and generate substantial medium- and long-term savings.

Generally speaking, one might think of the available policy options as falling into one of three categories: **Savers, Curve Benders, and Fundamental Reforms**. Savers focus on reducing the federal government's health costs, curve benders focus on slowing overall health spending growth, and fundamental reforms focus on changing the way health care is administered or financed.

Some may disagree on where to classify particular policies, both because many policies fall into multiple categories and because there is expert disagreement on the precise effect of various health changes. For simplicity, we have attempted to place policies in the category we believe they best (if not perfectly) fit – with the caveat that it is important to look at the merits of each policy in its entirety, rather than simply by classification below.

Savers

1. **Reductions to Provider Payment Rates.** The Medicare Payment Advisory Commission (MedPac) and other experts have recommended that Medicare reduce or modify its payments to numerous providers, including home health care providers, skilled nursing facilities, and rural hospitals. Recommendations have also been made to reduce or eliminate Medicare reimbursements for various unpaid deductibles and copays known as "bad debts." In addition, many proposals have reduced or reformed the reimbursements Medicare provides to hospitals for graduate medical education. Finally, a number of reforms have been recommended to replace the current "sustainable growth rate" (SGR) – a formula which was meant to control physician costs but has been in many ways unsuccessful – with a more sustainable formula that has the potential to both reduce and hopefully "bend" costs.

2. **Increases in Premiums.** Currently, most Medicare beneficiaries pay an annual premium equal to about a quarter of the costs of Medicare Part B and Part D – with higher earners paying more. These premiums could be increased across-the-board or could be further "means-tested" so that higher earners would contribute a larger share than they do today.

3. **Part D Drug Rebates.** Currently, Medicare Part D drug prices are set through negotiations between drug companies and insurance companies, while for Medicaid companies are required to provide "rebates" to the government to discount the costs of their drugs. Others have considered expanding these rebates to drugs purchased through Medicare Part D by those dually eligible for Medicaid – or expanding them further into the Medicare low-income subsidy (LIS) population.

4. **Raise the Medicare Age.** One option to reduce Medicare costs would be to change eligibility standards, including increasing the current eligibility age of 65 (perhaps to align with Social Security at 67). If PPACA remains in effect, roughly the bottom half of the income spectrum would be eligible for Medicaid or insurance subsidies under this option, while others would be required to acquire coverage through their employers or on the health care exchange market with no direct subsidy. This option has the advantage of increasing incentives for workers to remain in the labor force, thereby increasing

economic growth; however, despite government savings, economy-wide health care costs would likely increase somewhat.

5. **Reduce Federal Medicaid Contributions.** Currently, the federal government finances nearly 60 percent of Medicaid costs, with matches calculated through a Federal Medical Assistance Percentage (FMAP) formula on a state-by-state basis. The federal government could reduce its payments to states either by modifying the FMAP formula or otherwise changing federal contributions – for example by restricting the ability of states to tax Medicaid providers in order to increase provider payments. States could react to increased contribution requirements by reducing provider payments, encouraging more efficient delivery of care, reducing Medicaid services, or making tax and spending changes outside of the Medicaid program.

6. **Reduce PPACA Subsidies.** The PPACA includes insurance premium and cost-sharing subsidies on a sliding-scale basis for families making as much as 400 percent of the federal poverty line (about $90,000 of income for a family of four). Those subsidies could be cut back in any number of ways to reduce federal costs.

Curve Benders

1. **Reform Cost-Sharing Rules.** Currently, Medicare offers a hodge-podge of cost-sharing rules that are often too complex and confusing to encourage beneficiaries to utilize health services efficiently. This problem is exacerbated by the pervasiveness of supplemental plans (Medigap), which cover most cost-sharing liabilities, including routine costs. A number of policy changes related to Medicare cost-sharing could help to slow cost growth, including instituting copayments where none exist (i.e. home health), increasing first-dollar deductibles, or making structural changes to the entire cost-sharing system. In addition, Medigap plans could be restricted from covering first-dollar costs or charged for doing so. Other programs such as Medicaid could also look at utilizing more cost-sharing.

2. **Reform Medical Malpractice Laws.** One component of current health spending is the cost of medical malpractice insurance and lawsuits, as well as the secondary cost of increased "defensive medicine." These costs could be limited by making changes to the current tort system such as caps on non-economic and punitive damages, changes in statutes of limitations and rules about what evidence can be presented, limits on attorneys' fees, or establishment of alternative approaches to mediation (i.e. "health courts"), to name a few.

3. **Coordinate Dual Eligible Care.** Seniors who are eligible for both Medicare and Medicaid, often referred to as "dual eligibles," have some health care services covered by Medicare and some by Medicaid, but neither system takes responsibility for looking at their entire care. Dual eligibles are more likely to have complicated health conditions, which require coordination of care. Better care coordination – perhaps through managed care – has the potential to save money and improve quality.

4. **Change the Tax Treatment of Health Insurance.** Most economists believe that one of the drivers of growing health care costs is the tax exclusion of compensation in the form of employer-provided health insurance. This tax treatment encourages employers to offer more and more generous health insurance plans that do less to control costs from the provider or the beneficiary. Although the 2010 health care law would partially offset this favorable treatment with an excise tax on certain high-cost health plans

beginning in 2018, additional changes could be made either by expanding the excise tax or directly altering the exclusion. Although the tax treatment of health insurance is generally addressed in the context of tax reform, it is important to keep in mind the potential health care implications.

5. **Encourage Better Health.** General unhealthiness in the population is one cause of high per-capita health costs, particularly when it comes to obesity and smoking. Healthy behavior can be encouraged, and unhealthy behavior discouraged, through education programs, public health initiatives, and/or more stringent regulations or taxes on certain unhealthy behavior (for example, smoking or drinking).

Fundamental Reforms

1. **Strengthen the Independent Payment Advisory Board (IPAB).** One major reform enacted in the 2010 health care law was the creation of IPAB, a board of experts that has the authority and statutory requirement to limit Medicare cost growth. Under current law, though, IPAB is only permitted to modify certain provider payments. A strengthened IPAB could make recommendations on cost-sharing rules, fundamental payment reforms, benefit designs, and other reforms to better align cost-consciousness and higher quality health outcomes.

2. **Transform Medicare into Premium Support or Competitive Bidding Program.** One option to control Medicare costs would be to set a fixed government benefit each year and allow private (and in some cases public) insurance plans to compete over customers. Under most premium support plans, the federal government would provide subsidies to Medicare beneficiaries – with adjustments for age, health, and sometimes income – and allow them to purchase from a menu of qualified plans. Subsidies could be set based on "competitive bidding" (for example, benchmarked at the lowest bid in each region), limited to a certain growth rate (for example, GDP+1%), or calculated through some combination of the two. Many premium support plans would allow traditional Medicare to remain and compete against private companies, though some would eliminate it entirely for new beneficiaries.

3. **Reform the Fee-For-Service Model.** Currently, Medicare generally pays providers based on the quantity of tests and procedures they provide, rather than the resulting quality of care. The 2010 health care reform law put in place numerous pilot and demonstration projects which may begin to test new payment models – including through bundled payments, Accountable Care Organizations, value-based purchasing, and comparative effectiveness research. If changes like these could be expanded to the entire system in place of "fee for service," it might represent a fundamental reform to slow cost growth and improve delivery system efficiency. Short of that, policymakers could identify additional models for reform and give CMS the authority to accelerate the implementation and expansion of existing pilot programs (which might be classified as a "curve bender" rather than "fundamental reform").

4. **Block Grant Medicaid Payments.** Currently, states receive a federal match for the money they spend on Medicaid beneficiaries. Instead, the federal government could offer a fixed block grant for some or all Medicaid services and require the states to take responsibility for controlling costs or identifying the necessary funding stream to fund the program. Typically, such block grants begin by providing the same level of support as is currently in place, but are then indexed to a growth rate meant to control costs relative to current projections.

5. **Establish a Single Payer or All Payer System**. The federal government currently facilitates health insurance coverage through a variety of direct and indirect means – including through Medicare, Medicaid, and other government programs; through a tax benefit for private insurance purchased by employers; and, beginning in 2014, through subsidies for individuals purchasing insurance on an exchange. Instead, the federal government could take over most or full responsibility for insuring all citizens (single-payer), or set stricter prices and regulations for private insurance companies (all-payer).

6. **Budget for Health Care.** Currently, most federal health programs are structured as "entitlements" that give formula-specified benefits to all who qualify for each given program. One option is to put some or all federal health spending into a budget and limit the growth of the budget. Any of a number of enforcement mechanisms and procedural changes could be put in place to ensure that budget is met.

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The options listed above are not exhaustive, and each has many permutations and combinations. In all likelihood, health reform will be a continual process where policymakers must constantly work to find new efficiencies and improvements over time. Given the country's current and projected fiscal state, though, policymakers must begin now to enact as much savings as reasonably possible to begin to slow the growth of federal health spending and put the country on a stronger fiscal path.

Appendix: Select Health Care Policy Options and Savings

Policy Options	Savings Through FY2021
Savers	
Reductions to Provider Payment Rates	
Eliminate Medicare Payments for Bad Debts	$30 billion
Reduce Payments to Post-Acute Providers	$10-$40 billion
Reduce Payments for Graduate Medical Education	$10-$70 billion
Reduce Payments for Rural Hospitals	$5-$60 billion
Increases in Medicare Premiums	
Freeze Income Thresholds for Means-Tested Premiums	$10 billion
Increase Means-Tested Premium Levels	$10-$20 billion
Increase Part B Premiums from 25% to 35% of Costs	$240 billion
Introduce Part D Drug Rebates	
Apply Medicaid Rebates to "Dual Eligibles"	$55 billion
Apply Rebates to Low-Income Medicare Beneficiaries	$130 billion
Raise Medicare Age	
Raise Age to 67 Between 2014 and 2027	$125 billion
Raise Age to 67 Between 2014 and 2040	$60 billion
Reduce Federal Medicaid Contributions	
Introduce "Blended" Rate for Medicaid and CHIP	$15-$60 billion
Reduce Floor on Medicaid Matching Rate from 50% to 45%	$180 billion
Restrict State Use of Provider Taxes to Boost Federal Medicaid Match	$10-$50 billion
Repeal Maintenance of Effort Requirements from PPACA, Limit Territory Payments and CHIP Bonuses	$15 billion
Reduce PPACA Subsidies	
Recapture Excess Subsidies to Individuals	$35 billion
Reduce Coverage Expansion to Senate-Passed Levels	~$100 billion
Repeal Individual Mandate	$280 billion
Establish a Public Option for the Health Insurance Exchanges	$90 billion
Curve Benders	
Reform Cost-Sharing Rules	
Introduce Home Health Copayment	$1-$40 billion
Restrict Medigap Coverage of Cost-Sharing	$55 billion
Impose Surcharge or Surtax for Certain Medigap Plans	$2-$20 billion
Combine and Simplify Parts A and B Cost-Sharing into a Unified Deductible, Unifrom Copayment, and Out-of-Pocket Limit	$30-$75 billion

Policy Options (continued)	Savings Through FY2021
Reform Medicare Malpractice Laws	
Enact Comprehensive Tort Reform	$40-$55 billion
Enact Tort Reform Without Cap on Damages	$20 billion
Coordinate Dual Eligible Care	
Remove Barriers to States Placing Dual Eligibles in Managed Care (Domenici-Rivlin)	$10 billion
Mandate States Place Dual Eligibles in Managed Care (Fiscal Commission)	$15 billion
Change the Tax Treatment of Health Insurance	
Impose "Cadillac" Tax on High-Cost Plans in 2014 Instead of 2018 at 80th Percentile, and Index to Inflation from 2014 Levels	$310 billion
Repeal Health Care Exclusion for Medicare (Hospital Insurance) Payroll Tax	$210 billion
Encourage Better Health	
Increase All Taxes on Alcoholic Beverages to $16 per Proof Gallon	$60 billion
Increase Cigarette Tax by 50 Cents Per Pack	$40 billion^
Fundamental Reforms	
Strengthen IPAB	
Expand IPAB Authority to Make Recommendations on Cost-Sharing, Benefit Design, and Fundamental Payment Reform	N/A
Reduce IPAB's Target Growth Rate Per Beneficiary from GDP+1% to GDP+0.5%	$0-$5 billion*
Transition Medicare to a Premium Support System	
Pilot Premium Support in the FEHB Program	$20 billion
Enact Medicare "Defined Support" Starting in 2016 (Domenici-Rivlin)	$150 billion
Block Grant Medicaid	
Block Grant Medicaid Long-Term Care Services, Grow with ECI	$290 billion
Block Grant Medicaid, Grow with Inflation Plus Population Growth	$600-$650 billion

Note: All numbers are rounded and estimated by the Committee for a Responsible Federal Budget, generally based on CBO scores.
^About 10% of the savings are a result of lower health care costs on top of the direct revenues from the tax.
*Based on Administration's IPAB proposal, including interactions with other health changes.