Hearing before the House Committee on Energy and Commerce, Health Subcommittee
"Setting Fiscal Priorities: Reforming Health Spending and Strengthening Our Future"
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Testimony of Marc Goldwein
Senior Policy Director, Committee for a Responsible Federal Budget

Chairman Pitts, Vice Chairman Dr. Burgess, Ranking Member Pallone, and other members of the Subcommittee:

Thank you for inviting me to discuss how our country can best reform and improve our Medicare and Medicaid programs. The fiscal challenges we face as a nation are immense. Despite the recent slowdown in health care cost growth, making additional reforms to Medicare and Medicaid is of central importance to keeping future health care cost growth under control and putting our debt on a sustainable long-term path. Moreover, there are a number of common-sense improvements to Medicare and Medicaid that I believe could and should receive bipartisan support. Thank you for holding this hearing and for inviting me to share my thoughts on these improvements.

I am Marc Goldwein, Senior Policy Director of the Committee for a Responsible Federal Budget (CRFB). CRFB is a non-partisan organization dedicated to educating the public on matters of fiscal importance. Our organization is chaired by former Congressmen Charlie Stenholm, Jim Nussle, and Tim Penny, and the board is made up of past directors of the Office of Management and Budget, the Congressional Budget Office, the Federal Reserve System, the Treasury Department, and the Budget Committees, as well as many of the top experts on budget issues. Until his passing last month, Congressman Bill Frenzel – who served in this body honorably for two decades – also chaired CRFB.[1]

In addition to my work at CRFB, I served as Associate Director of the National Commission on Fiscal Responsibility and Reform (the Simpson-Bowles Fiscal Commission) and as a Senior Budget Analyst for the Joint Select Committee on Deficit Reduction (the Hensarling-Murray Super Committee), and I have been involved in a number of other bipartisan efforts which have worked to reform and slow the growth of the nation's health care programs.

CRFB also has recently released its own plan – the Paying for Reform and Extension Policies Plan (or the **PREP Plan**) – that would pay for a permanent reform to the Sustainable Growth Rate formula with changes designed to improve incentives within the Medicare program.[2]

Based on my work in these various efforts, it has become increasingly clear that there are no easy choices in health reform, and few if any changes that produce all winners and no losers. Given the vast inefficiency and misaligned incentives in the health care system, however, it is certainly possible to identify reforms that create more or bigger winners than losers by improving the way we deliver and consume health care and reforms that allocate resources to where they are needed most.

[1] See http://www.crfb.org/ for more information about the organization.
[2] For details, read CRFB's "PREP Plan: Paying for Reform and Extension Policies," November 2014. http://crfb.org/document/prep-plan-paying-reform-and-extension-policies

Before discussing these policies, I would like to offer some brief context on the country's fiscal situation.

The national debt is currently at a record high and at a level seen only once before as a share of the economy – for a brief period around World War II. Although our annual deficits have indeed declined by about two-thirds since 2009, that decline follows a nearly ***800 percent*** increase brought on by the Great Recession and largely reflects the slow but increasingly apparent economic recovery. [3]

Under current law, deficits are projected to bottom out in 2015 and return to above $1 trillion less than a decade later. Assuming Congress and the President choose to renew the expired tax extenders and various other provisions, deficits will never be as low as they were in 2014 and could exceed $1.5 trillion by 2025.[4] As a percent of GDP, deficits will rise to between 4 and 6 percent by 2025.

Under either scenario, debt will exceed the size of the economy sometime in the 2030s and will double the size of the economy between 2045 and 2080 as health and retirement spending continue to grow while revenues do not keep up. According to the Congressional Budget Office (CBO) and most experts, this rise in debt will crowd out productive investment, slow long-term economic growth, raise interest rates throughout the economy, reduce the government's ability to address new needs or respond to emergencies, and increase the fiscal and economic burden on future generations. Ultimately, ever growing debt levels would be unsustainable and, if not stopped proactively, would create the need for abrupt and painful austerity, cause a harmful fiscal crisis, or both.[5]

Avoiding these adverse effects will require addressing the largest and fastest growing components of our budget – Social Security, Medicare, Medicaid, and other health spending – in addition to raising more revenue. Attention on federal health spending is particularly important, since Medicare and Medicaid spending alone has grown from 1.9 percent of GDP in 2000 to 4.8 percent today, and is projected to reach 8.5 percent of GDP by 2050. Meanwhile, discretionary budgets are *declining* as a share of GDP, and revenue is rising, but not fast enough.

The bottom line is that our debt is high and growing, and it will be almost impossible to reverse that trend without addressing the growth of federal health spending.

I would like to make four main points in my remarks today:

1. **Despite the recent slowdown in health care spending, it remains incredibly important that policymakers pursue reforms to reduce future projected health care costs.**
2. **Policymakers should focus first and foremost of health cost "Benders" that would improve incentives in order to slow the overall growth of health care spending.**
3. **Policymakers should next look to health cost "Savers," which reduce federal costs by better allocating resources within the federal health programs.**
4. **Given the aging of the population, health reforms will be necessary but not sufficient to put the debt on a sustainable long-term track.**

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[3] See CRFB, "Deficit Falls to $483 Billion, But Debt Continues to Rise," October 2014 http://crfb.org/document/report-deficit-falls-486-billion-debt-continues-rise

[4] Ibid.

[5] See Congressional Budget Office, "The 2014 Long-Term Budget Outlook," Page 19. July 2014. www.cbo.gov/sites/default/files/45471-Long-TermBudgetOutlook_7-29.pdf#page=19

Our Health Care Cost Problems are Far From Solved

The recent slowdown in health care spending has been impressive, and should be greeted as welcomed news for those concerned about our long-term fiscal situation. At the same time, however, this slowdown should *not* be used as an excuse to delay or desist efforts to reform the Medicare and Medicaid programs.

So far this year, national health expenditures have grown by only 4.7 percent over last year despite the expansion of health coverage from the Affordable Care Act.[6] More relevant for our purposes, Medicare spending last fiscal year grew by only 2.7 percent – the fourth lowest growth rate in history – despite a 3.8 percent increase in in the number of beneficiaries.[7] In other words, per beneficiary costs have actually *shrunk* in nominal terms, despite relatively normal levels of inflation and economic growth.

In large part because of these recent trends, the Congressional Budget Office (CBO) has revised down its future health care cost projections significantly. The agency now projects Medicare spending between 2012 and 2021 to be more than $500 billion lower than projections they made in March of 2011.[8]

Both the current slowdown and projected future slowdown represent reasons for hope. But for a number of important reasons, they should not be used an excuse to abandon further health reform efforts. ***Indeed, the Congressional Budget Office still projects that federal health care spending – which consumed 3 percent of GDP in the year 2000 – will grow from less than 5 percent of GDP today to above 6 percent in 2025, 9 percent in 2050, and more than 13 percent by 2085.***

The below discussion focuses on why the recent *Medicare* slowdown is not a reason to abandon health reforms, but the same is largely true for other federal health programs.

A Large Portion of the Slowdown is Likely Temporary

No one fully understands what is driving the slowdown in Medicare spending, and experts disagree on its root causes. At this point, it seems clear that at least some portion of the slowdown represents a structural change in the growth rate of Medicare. However, evidence suggests that a good portion of the slowdown is also due to one-time factors that are unlikely to continue in the future. These one-time factors are legislative, demographic, economic, and idiosyncratic.

Legislative Causes. A portion of the slowdown in the Medicare growth rate is the result of one-time cuts legislated in the Medicare program. Specifically, the Affordable Care Act included a number of reductions to provider and Medicare Advantage payments that went into effect in the last couple years. In addition, the "sequestration" resulting from the failure of the Super Committee reduced most Medicare spending by 2 percent. Our analysis of the growth in Medicare spending between 2013 and 2014 found that when you remove these legislative factors, the underlying growth rate of Medicare was 4.9 percent rather than 2.7 percent.[9] Importantly, this still suggests a reduction in inflation-adjusted per beneficiary Medicare costs, but not nearly as large as the headline number.

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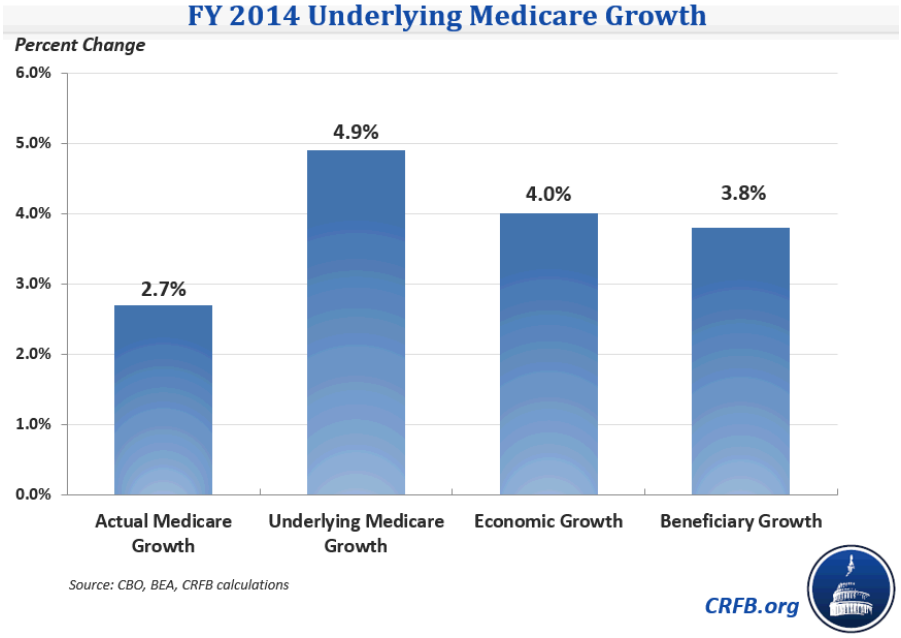
[6] Altarum Institute, "Health spending continues moderate growth through third quarter," November 2014. http://altarum.org/sites/default/files/uploaded-related-files/CSHS_SpendingBrief_November2014_04.pdf

[7] CRFB, "Medicare Registers Fourth Lowest Growth Rate in Program History in 2014," October 2014. http://crfb.org/blogs/medicare-registers-fourth-lowest-growth-rate-program-history-2014.

[8] Loren Adler and Adam Rosenberg, "The $500 Billion Medicare Slowdown: A Story About Part D," *Health Affairs,* October 2014. http://healthaffairs.org/blog/2014/10/21/the-500-billion-medicare-slowdown-a-story-about-part-d/

[9] See footnote 5.



Demographic Causes. As the baby-boom population enters Medicare, it reduces the average age of Medicare beneficiaries. Younger Medicare beneficiaries in their 60s, not surprisingly, tend to have lower annual health care costs than those in their 70s, 80s, and 90s. According to a working paper by Michael Levine and Melinda Buntin at CBO ("the CBO working paper"), the increase in younger Medicare beneficiaries accounted for about ten percent of the slowdown between 2000-2005 and 2007-2010.[10] Unfortunately, this trend will reverse and worsen as the Baby Boomers age into their 80s and 90s over the next few decades.

Economic Causes. The "great recession" and accompanying low GDP growth and inflation have likely played a substantial role in slowing overall health care costs in the United States as well as most other developed nations.[11] The CBO working paper attributes as much as one-eighth of the slowdown in Medicare Parts A & B spending to these economic factors, and the fact that Medicare is tracking National Health Expenditures to some degree suggests the possibility that some additional portion of the slowdown (the CBO working paper cannot explain 75 percent) is related to the economic slowdown.

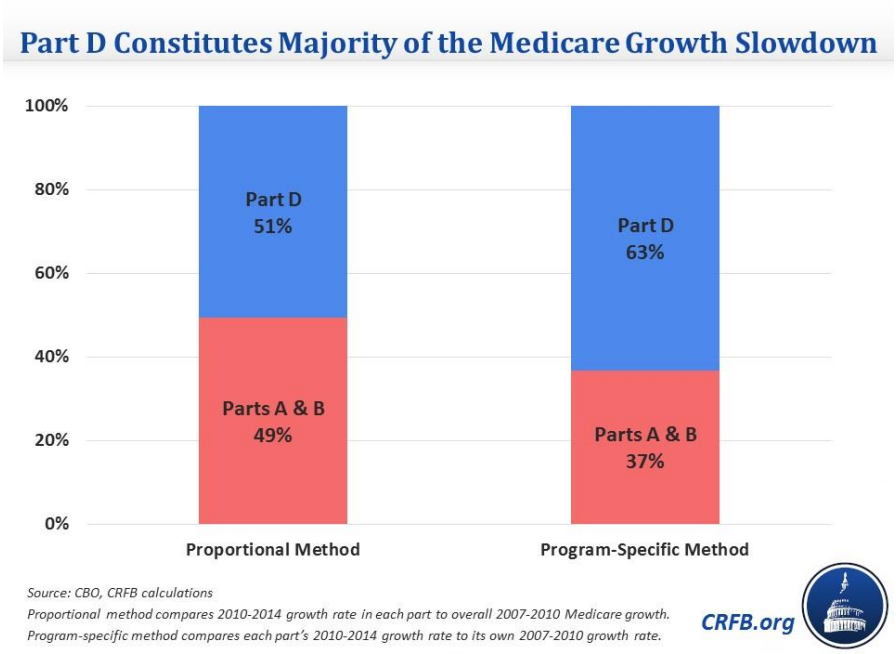
Idiosyncratic Causes. A number of changes occurring in the Medicare program might represent one-time rather than permanent changes in the program's growth rate. Most notably, a large portion of the slowdown appears to be due to the "patent cliff," in which a number of expensive blockbuster prescription drugs happen to be coming off patent all in a short period of time. Medicare Part D represents only around one tenth of the Medicare program, yet according to analysis from my colleagues Loren Adler and Adam Rosenberg, it is responsible for between half and two thirds of the slowdown.[12] The disproportionate role

[10] Michael Levine and Melinda Buntin, "Why Has Growth in Spending for Fee-for-Service Medicare Slowed?" August 2013. http://www.cbo.gov/publication/44513

[11] For example, see David Squires, "The Global Slowdown in Health Care Spending Growth," *The Journal of the American Medical Association,* August 2014. http://jama.jamanetwork.com/article.aspx?articleid=1885447. Also see Margot Sanger-Katz. "The Global Slowdown in Medical Costs," *The New York Times*, July 2014. http://www.nytimes.com/2014/07/17/upshot/the-global-slowdown-in-medical-costs.html?abt=0002&abg=1&_r=0

[12] See footnote 6 and CRFB, "Another Way to Look at the Medicare Slowdown," October 2014. http://crfb.org/blogs/another-way-look-medicare-slowdown

played by Medicare Part D happening at the very same time as the patent cliff represents yet more evidence that a portion of the slowdown may prove temporary.



The Slowdown May Depend on Future Health Reforms

Somewhat paradoxically, a portion of the slowdown may be a result of what health providers *expect* federal policy to be rather than what it is. There is increasing evidence of structural changes in the way health care is being delivered, despite such changes not always reflecting the incentives currently in place. For instance, a recent analysis from Catalyst for Payment Reform found private payments through value-oriented payment models have quadrupled since last year to 40 percent of all payments.[13] Similar shifts away from pure fee-for-service reimbursement are beginning to happen in Medicare as well with the growth of Accountable Care Organizations. Yet there is little evidence this shift is very profitable for providers.

One explanation is that providers are beginning to slowly shift away from fee-for-service today in anticipation of further changes in Medicare payment systems, and the effect that might have on private reimbursement schemes. To the extent this is true, maintaining the health care slowdown will require public policy to realize these expectations. As former CBO and OMB director Peter Orszag has argued, the slowdown suggests "policy makers should be more aggressive in moving Medicare away from fee-for-service payments," not less.[14]

With An Uncertain Slowdown, Declaring Victory is Premature

Although it is possible the CBO and others are overstating future Medicare cost growth, it is also possible they are understating its growth. The fact that experts cannot agree on the causes of the slowdown – and

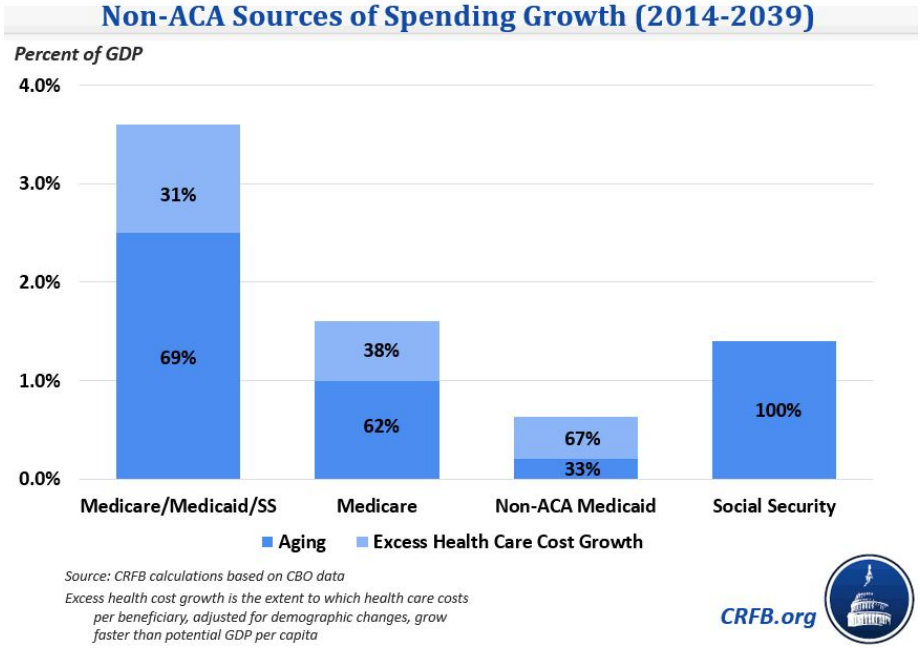
[13]Suzanne Delblanco, "The Payment Reform Landscape: Value-Oriented Payment Jumps, And Yet …" *Health Affairs,* September 2014. http://healthaffairs.org/blog/2014/09/30/the-payment-reform-landscape-value-oriented-payment-jumps-and-yet/

[14] Peter Orszag, "Yes, We Can Trim Medicare Spending," *Bloomberg View*, February 2014. http://www.bloombergview.com/articles/2014-02-11/yes-we-can-trim-medicare-spending

even the CBO working paper fails to explain 75 percent of it – suggests that policymakers should proceed with caution. Medicare reforms tend to phase in savings slowly. If it turns out Medicare cost growth slows much further than currently anticipated, it will be easy to return the gains in the form of better Medicare coverage, more generous provider payments, lower Medicare premiums, lower taxes, higher spending on other important programs, and/or a lower national debt. However, if Medicare spending grows faster than projected, the steps taken to keep Medicare's growth under control will have been all the more important and hopefully will allow lawmakers to learn from those steps to pursue further reforms.

Aging Represents the Primary Driver of Growing Entitlement Costs

Even a sustained slowdown in health care cost growth is unlikely to keep debt from rising because health care costs alone are not driving the growth in entitlement spending. In fact, projected health care cost growth is not even the primary cause of growth in entitlement spending over the next quarter century. According to CBO, "excess cost growth" – the amount by which health costs grow faster than GDP per capita – is responsible for only 30 percent of the non-ACA spending increases over the next quarter century. The remaining 70 percent is the result of population aging, both from the retirement of the baby



boom population and continued increases in life expectancy. Even removing Social Security, population aging is responsible for 55 percent of non-ACA spending growth over the next 25 years.[15]

The fact that aging is responsible for such a large portion of spending growth suggests that no realistic slowdown in per capita health spending will be sufficient to keep total entitlement spending from rising as a share of GDP. Indeed, a recent analysis from Alan Auerbach, Bill Gale, and Benjamin Harris found that even with 0 percent excess cost growth, debt would continue to grow as a share of GDP.[16] As a result,

[15] CRFB, "Drivers of the Debt: Aging in the Medium Term, Health Costs over the Long Term," July 2014. http://crfb.org/blogs/drivers-debt-aging-medium-term-health-costs-over-long-term

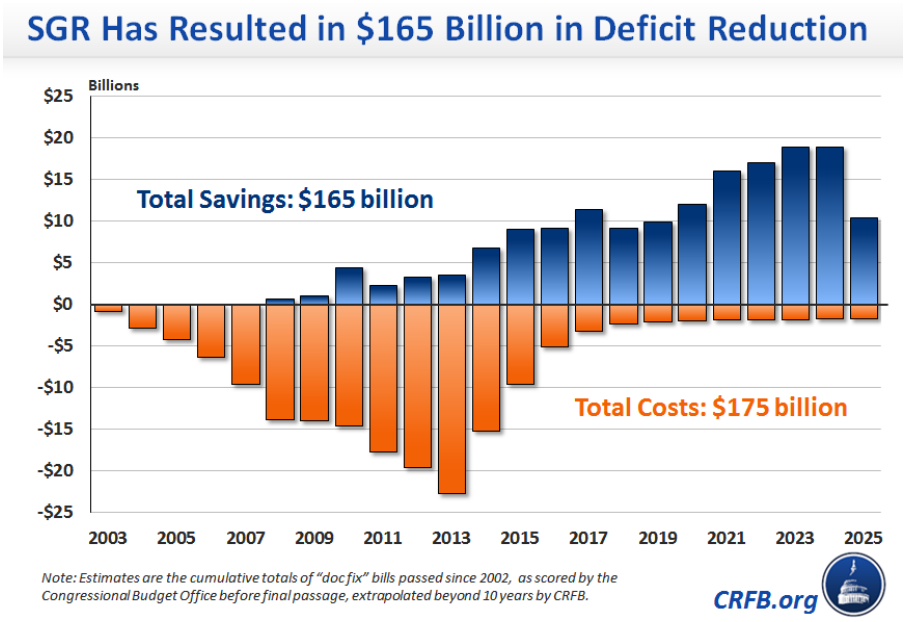
[16] Alan Auerbach, William Gale, and Ben Harris, "Federal Health Spending and the Budget Outlook: Some Alternative Scenarios," April 2014. http://www.brookings.edu/~/media/events/2014/04/11%20health%20care%20spending/federal_health_spending_budget_outlook_auerbach_gale_harris.pdf

policymakers will either need to slow per capita federal health care cost growth to below GDP growth, mitigate the effects of the aging population (which I will explain later), increase tax revenue, reduce other spending, or do some combination. And the fact that discretionary spending has already been cut so significantly, and revenue will rise above historic levels (though well below where it was when we last balanced the budget) suggests fewer available options than just a few years ago.

Policymakers Must Fix the SGR and Hospital Insurance Trust Fund

Even if Medicare cost growth were no longer a threat to the federal debt situation, there remains a need to identify reforms in order to comply with several important budgetary rules. Most immediately, physicians face a 21 percent cut in payments this April as a result of the Sustainable Growth Rate (SGR). A one-year "doc fix" to avoid this cut would cost about $15 billion, which would need to be fully offset to comply with Pay-As-You-Go (PAYGO) rules and avoid adding to the debt. A permanent fix, depending on the details, could cost anywhere from $120 to $180 billion.[17]

Although Congress has continuously waived mandated SGR cuts since 2003, they have also almost always paid for "doc fixes" with alternative deficit reduction measures. In fact, policymakers have generally replaced SGR cuts with alternative health savings, including a number of small structural curve-bending changes. By our analysis, doc fixes have been offset 98 percent of the time since 2004.[18] In other words, the SGR has helped to indirectly control Medicare costs in the past, and future doc fixes or SGR reform must be fully offset to ensure it continues to do so in the future.



CRFB's **PREP Plan** has put forward a specific set of sensible provider and beneficiary reforms to slow health care cost growth *and* pay for a permanent replacement of the SGR with an improved formula akin to the one developed by this Committee, along with the Finance and Ways & Means Committees.[19]

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[17] See Congressional Budget Office, "Medicare's Payments to Physicians," November 2014. http://www.cbo.gov/publication/49770. Also see CRFB, "New CBO Estimates Set the Stage for 'Doc Fix' Discussions," November 2014. http://crfb.org/blogs/new-cbo-estimates-set-stage-doc-fix-discussions

[18] CRFB, "Actually, the SGR Has Slowed Health Care Cost Growth" March 2014. http://crfb.org/blogs/actually-sgr-has-slowed-health-care-cost-growth

[19] See footnote 2.

In addition to identifying SGR offsets, policymakers will eventually need to put forward measures to avoid insolvency of the Medicare Part A Hospital Insurance trust fund projected around 2030.

Focus First on Health Care Cost "Benders"

Policymakers have a number of options for slowing the growth of federal health spending. Many of those who work on health reform like to divide these options between those primary impacting beneficiaries and those primary affecting providers. However, at CRFB, we think it is much more useful to categorize reforms based on whether they operate by changing incentives, making cuts, or transforming the system – what we call "**Benders," "Savers," and "Structural Reforms."** I'd like to focus today on changes with the potential for bipartisan support, which fall primarily in the "benders" and "savers" categories – excluding the more controversial "structural reforms" for now.

Potential Bipartisan Health Care Savings Options

Policy	10-Year Savings
Benders	
Modernize Medicare Cost-Sharing by Creating Unified Deductible and OOP Limit	$0-$100 billion
Restrict Use of Medigap Wrap-Around Plans Covering 1st-Dollar Costs	$55 billion
Impose Premium Surcharge for Certain Medigap Plans	$5-$35 billion
Impose Premium Surcharge on Certain Employer-Sponsored Retiree Health Plans	$5-$25 billion
Restrict TRICARE-for-Life Supplemental Plans from Covering 1st-Dollar Costs	$30 billion
Expand the Use of Bundled Payments	$5-$50 billion
Encourage Low-Cost Physician-Administered Drugs in Medicare Part B	$5-$10 billion
Expand Penalties for Preventable Readmissions and Complications	$1-$50 billion
Equalize Payments for Similar Services in Different Settings	$10-$30 billion
Modify Co-Pays for the Part D Low-Income Subsidy to Encourage Generic Drugs	$25 billion
Ban "Pay-for-Delay" Drug Agreements, Reduce Patent Period for Certain Drugs	$5 billion
Enact Medical Malpractice Reform	$5-$70 billion
Savers	
Reduce Payment Updates for Post-Acute Care Providers	$15-$75 billion
Eliminate Medicare Reimbursement for Bad Debts	$50 billion
Reduce Payments for Graduate Medical Education	$10-$60 billion
Reduce Payments to Rural Hospitals	$2-$50 billion
Increase Medicare Advantage Coding Intensity Adjustment	$15 billion
Extend and Increase Medicare Income-Related Premiums	$25-$100 billion
Modify Medicaid Drug Manufacturer Rebate	$5-$20 billion
Increase Drug Rebates in Part D	$65-170 billion
Reduce Medicaid Provider Tax Gimmick	$10-$60 billion
Set FMAP for Administrative Costs at 50%	$25 billion
Repeal ACA Exchange Subsidies for Incomes Above $300 billion	$120 billion
Reduce FMAP Medicaid Payments to States	Dialable

Savings estimates are *very rough,* and generated by CRFB staff primarily based on CBO estimates

As policymakers search for savings within the health care system, they should first look to cost "benders" – those policies which change incentives in order to slow overall health care cost growth. Importantly, there is no free lunch in the health care system, and those who suggest we can make everyone better off at once are probably overstating the case. At the same time, evidence suggests that inefficiencies,

misaligned incentives, and a lack of good information are clearly leading to a very substantial amount of health care spending that does little or nothing to improve overall health. This suggests an opportunity for at least a "discounted lunch" if policymakers are willing to focus on policies that improve these incentives and reduce inefficiency.

In my view, it is far preferable to focus on policies that reduce the overutilization or mis-utilization of health care in order to slow health care cost growth than it is to simply shift who pays, who receives, and how much. This is true even for those policies that use targeted (and budget-saving) cuts as the "stick" to improve incentives.

Indeed, our **PREP Plan** focused almost exclusively on these "benders" and identified enough of them to fully offset the cost of the bipartisan Tricommittee SGR reform bill along with the health care extenders.[20] Below, I discuss a number of "bender" policies, including a range of potential savings along with the savings achieved from the PREP plan proposals in parentheses.

A comparison table of policies included in different plans can be seen at http://crfb.org/sites/default/files/final_delivery_systems_reform_paper_0.pdf#page=28

Reform Medicare Cost-Sharing Rules – $0 billion to $100 billion (~$20 billion)

Controlling health care cost growth will require wise consumption of health care services. Yet Medicare Parts A and B currently have a hodgepodge of deductibles, co-pays, and other cost-sharing requirements that are too complex, confusing, and uneven to establish the correct incentives for beneficiaries. Overall, Medicare probably requires too little "skin in the game" for first-dollar coverage, while putting beneficiaries at risk by offering too little protection against catastrophic costs.

A number of plans, including those from Simpson-Bowles, Domenici-Rivlin, MedPAC, the American Enterprise Institute (AEI), the Bipartisan Policy Center (BPC), the Center for American Progress (CAP), the Urban Institute, and our own PREP plan would replace the current rules with a more straightforward and combined cost-sharing regime.[21] For example, the PREP plan would establish a combined deductible of about $600, uniform coinsurance of 20 percent for all non-preventative services, and provide a $6,000 limit on out-of-pocket costs to protect beneficiaries from medical bankruptcy. It would also include reduced cost-sharing for lower-income seniors so that they could better afford their medical bills and further limit their out-of-pocket exposure.

Importantly, a comprehensive cost-sharing reform can be designed to reduce federal costs without increasing net out-of-pocket costs for seniors, simply by reducing excess utilization. Combined with supplemental coverage restrictions (described below), in fact, a plan can significantly *reduce* costs both

[20] Ibid.

[21] The Moment of Truth Project, "A Bipartisan Path Forward to Securing America's Future," April 2013. http://crfb.org/document/report-bipartisan-path-forward-securing-americas-future
The Debt Reduction Task Force, "Restoring America's Future," November 2010. http://bipartisanpolicy.org/wp-content/uploads/sites/default/files/files/BPC%20FINAL%20REPORT%20FOR%20PRINTER%2002%2028%2011.pdf
Joseph R. Antos, Mark V. Pauly, and Gail R. Wilensky, "Bending the Cost Curve through Market-Based Incentives." *New England Journal of Medicine,* September 2012. http://www.nejm.org/doi/full/10.1056/NEJMsb1207996
Bipartisan Policy Center, "A Bipartisan Rx for Patient-Centered Care and System-wide Cost Containment," April 2013. http://bipartisanpolicy.org/library/report/health-care-cost-containment
Center for American Progress, "The Senior Protection Plan," November 2012. https://www.americanprogress.org/issues/healthcare/report/2012/11/13/44590/the-senior-protection-plan/
Robert Berenson, John Holahan, and Stephen Zuckerman, "Can Medicare Be Preserved While Reducing the Deficit?," March 2013. http://www.urban.org/publications/412759.html

for the federal government and for Medicare beneficiaries. Initial estimates from the Actuarial Research Corporation (ARC) suggest the PREP Plan's benefit redesign and supplemental insurance reforms would reduce average out of pocket costs by nearly *$225 per person* each year.

Note that if policymakers are unable to pursue comprehensive cost-sharing reform, incremental reforms such as those in the President's budget are also possible. For example, lawmakers could modestly increase the Medicare Part B deductible and/or could impose cost-sharing where little or none currently exists, such as for home health episodes and clinical labs.

Restrict Supplemental Coverage – $5 billion to $110 billion (~$60 billion)

The ability of Medicare cost-sharing to control costs – either under current law or as proposed above – is limited by supplemental private insurance plans that piggyback on Medicare by financing remaining out-of-pocket costs. This supplemental coverage comes in a number of forms, with 30 percent of seniors in traditional Medicare covered by employer-provided retire health plans and one-fifth purchasing their own "Medigap plans," as of 2010.[22]

Unfortunately, these plans tend to be a bad deal for both beneficiaries and the federal government. A MedPAC-contracted study found that beneficiaries with Medigap plans cost Medicare 27 percent more in 2003-2008 than those without supplemental coverage.[23] And because of the high premiums associated with the plans, they spend up to $415 more out of pocket each year on average than they would if those plans were restricted.[24]

A number of plans including from Simpson-Bowles, the President's budget, MedPAC, BPC, AEI, the Brookings Institution, the Urban Institute, and our PREP plan would restrict or discourage the use of Medigap plans in some way. [25] The PREP plan would ban Medigap plans from covering the new Medicare deductible and only allow them to cover half of coinsurance costs, with temporary grandfathering for existing plans.

The PREP plan also allows employees to "cash out" their employer-provided retiree health plans in exchange for a premium subsidy, charging an additional Medicare premium for those who keep their plans in order to cover the cost imposed on Medicare and taxpayers. Some plans would apply a similar approach to Medigap plans instead of restricting them outright. And some plans would also restrict TRICARE-for-Life supplemental coverage from covering first-dollar costs as well.

Expand Bundled Payments and Promote New Payment Models – $5 billon to $50 billion ($40 billion)

Medicare generally pays each provider separately for their contribution to a single episode of care, creating incentives for each provider to increase utilization and providing no incentive to coordinate services. Ultimately, Medicare will need to move away from this "fee-for-service" payment model toward

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[22] Medicare Payment Advisory Commission, "June 2014 Report to Congress: Medicare and the Health Care Delivery System," June 2014. http://www.medpac.gov/documents/publications/june-2014-data-book-section-3-medicare-beneficiary-and-other-payer-financial-liability.pdf?sfvrsn=2

[23] Christopher Hogan, "Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly," August 2014. http://medpac.gov/documents/contractor-reports/august2014_secondaryinsurance_contractor.pdf?sfvrsn=0

[24] See Kaiser Family Foundation, "Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs." July 2011. http://www.kff.org/medicare/upload/8208.pdf.

[25] See footnote 21 and Jonathan Gruber, "Restructuring Cost Sharing and Supplemental Insurance for Medicare," February 2013. http://www.brookings.edu/research/papers/2013/02/medicare-cost-sharing-supplemental-insurance

one that rewards quality, efficiency, and care coordination. Congress should continue to work to promote such alternative models – including Accountable Care Organizations (ACOs) and patient-centered medical homes (PCMHs) – but they should not wait until these models are fully ready for primetime to begin pursuing reforms.

Medicare already has some experience offering "bundled payments," a single payment per episode of care in order to encourage providers to improve coordination and maximize cost-effectiveness of care based on a patient's needs. A number of plans, including the President's Budget, Simpson-Bowles, CAP, AEI, Brookings, the National Coalition on Health Care (NCHC), the Commonwealth Fund, and the PREP Plan would expand bundle payments in some ways.[26] The PREP Plan would eventually mandate bundled payments for the inpatient stay and 90 days of post-acute care for a number of conditions, while also using these bundles to reduce identified overpayments in post-acute care.

Encourage Low-Cost Physician-Administered Drugs – $5 billion to $10 billion ($10 billion)

Physicians are currently paid for administering drugs covered under Medicare Part B at the Average Sales Price (ASP) of the drug plus six percent. By paying the doctor a percentage of the drug cost – even though more expensive drugs do not necessarily entail any more work to administer – this policy encourages physicians to use the most expensive, rather than the most effective, drug available. A number of plans would reduce this incentive. The President's budget would reduce the payment to the ASP+3 percent. BPC and NCHC would convert it to a flat fee at a similar level (on average) as current law. And the PREP plan would effectively do both.

Reduce Preventable Readmissions & Unnecessary Complications – $1 billion to $50 billion ($10 billion)

The Affordable Care Act included a Hospital Readmissions Reduction Program, which penalizes hospitals for high readmission rates for certain medical conditions. At least in part because of this program, readmissions are down 8 percent since 2011.[27] A number of plans, including from the President's Budget, Simpson-Bowles, Urban, Brookings, CAP, NCHC, the Commonwealth Fund, and the PREP Plan would expand this program. The PREP Plan specifically would expand the penalties to more medical conditions and types of providers and increase the maximum penalty amounts. In addition, it discusses applying the ACA's penalties for hospital-acquired conditions to other avoidable complications.

Equalize Payments for Similar Services in Different Settings – $10 billion to $30 billion ($20 billion)

Medicare often pays vastly different rates for similar health care services based on the setting in which they are performed, encouraging providers to perform the service in the higher-paid site of care (for instance, in a hospital outpatient department rather than a freestanding physician's office). In many cases, there is no additional value to a service being performed in a more intensive or costly setting. A number of proposals, including from the President's budget, MedPAC, Simpson-Bowles, NCHC, CAP, and the PREP Plan would begin to reduce some of these disparities. PREP would equalize payments at the level of the lowest-cost site for certain services that are performed both in a hospital outpatient department and in a physician's office. This reform would complement efforts to encourage care coordination without

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[26] See footnote 21 and National Coalition on Health Care, "Curbing Costs, Improving Care: The Path to an Affordable Health Care Future," November 2012. http://www.nchc.org/plan-for-health-and-fiscal-policy/ The Commonwealth Fund, "Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System," January 2013. http://www.commonwealthfund.org/Publications/Fund-Reports/2013/Jan/Confronting-Costs.aspx

[27] Department of Health and Human Services, "New HHS Data Shows Major Strides Made in Patient Safety, Leading to Improved Care and Savings," May 2014. http://innovation.cms.gov/Files/reports/patient-safety-results.pdf

increasing cost and would reduce the incentive for hospitals to buy freestanding physician offices to generate higher Medicare reimbursements.

Promote the Use of Generic Drugs – $5 billion to $30 billion

In a number of cases, Medicare Part D and other federal programs do not do enough to discourage beneficiaries from purchasing brand-name drugs where there is a therapeutically-equivalent but lower cost generic alternative. In the Medicare Part D Low Income Subsidy (LIS) program, for example, beneficiaries pay only slightly more for brand name drugs even though the difference in cost to the federal government can be quite substantial. A number of policies could be designed to promote the use of generic drugs. For example, the President's budget would widen the difference between generic and brand name copays in the LIS, ban so-called "pay-for-delay" agreements designed to prevent manufacturers from bringing generic drugs to market, and reduce the patent period for certain types of brand-name drugs. The NCHC would also incentivize state encouragement of generic drugs in Medicaid by sharing savings and close a loophole that raises barriers to the creation of generic drugs.

Enact Medical Malpractice Reform – $5 billion to $70 billion

Medical malpractice cases tend to drive up health care costs by increasing the malpractice insurance premiums faced by doctors and by excessively increasing the practice of defensive medicine. A number of options could help to reduce the number or cost of malpractice cases. Modest savings could be achieved by limiting certain statutes of limitations, establishing a "fair share rule" in favor of "joint-and-several liability," allowing courts to consider collateral sources of income (such as life insurance payouts) in determining payment amounts, limiting lawyer fees, promoting "health courts" or other types of arbitration, providing "safe havens" for physicians who follow best practices, or giving states more incentive to experiment with their own reforms. Hard limits on noneconomic and punitive damages would generate larger savings, both for the federal government and private health spending.

Encourage State Innovation in Medicaid

Nearly 40 percent of federal health spending goes to Medicaid. Yet because it is a joint program administered by the states, the federal government has less ability to "bend the cost curve" within the Medicaid program as in other programs. On the other hand, the fact that there are 56 different Medicaid programs offers at least 56 different laboratories to test new cost control ideas – and often the best ideas come from the states. To ensure these cost control ideas are pursued, tested, and expanded where successful, the federal government should allow and aggressively encourage states to pursue a variety of ideas aimed at slowing health care cost growth. Expanded waiver authority was proposed in Simpson-Bowles, the PREP Plan, and to some degree in the President's budget. The Leavitt Medicaid Commission of 2006 and the National Governor's Association Health Care Sustainability Task Force have outlined how it could work in great detail.[28]

In addition to providing waivers, the federal government may be able to promote Medicaid savings by easing certain Medicaid regulations, reducing matching payments for certain low-value services, and

[28] See the Medicaid Commission, "Final Report and Recommendations," December 2006. http://www.allhealth.org/briefingmaterials/HHS-MedicaidCommissionReport-638.pdf. Also see the Health Care Sustainability Task Force, "NGA Health Care Sustainability Task Force Report," February 2014. http://www.nga.org/cms/home/special/col2-content/nga-health-care-sustainability-t.html.

promoting new coordinated care models to treat "dual-eligible" beneficiaries who qualify both for Medicare and Medicaid.

Reforms to the Affordable Care Act

Working within the general structure of the ACA, some reform options have potential to bend the cost curve. In light of efforts to shift away from fee-for-service payment system-wide, stronger incentives could be provided to exchange plans to utilize ACO-like delivery models and value-based purchasing. Increasing the availability of cost data for patients, particularly given that most ACA plans include a sizeable deductible, holds potential for reducing health costs. One key pathway to controlling costs would be to improve competition between health plans on the exchanges, both by making plan comparisons clear and simple and encouraging annual shopping among plans.

Other proposals have sought to increase cost-sharing further within exchange plans, either by adding catastrophic coverage as an option for all buyers or by switching the premium subsidy to be based on the cost of Bronze, rather than Silver, plans.

Look to the "Savers" To Better Allocate Limited Health Resources

Although policymakers should focus mainly on those policies that help to "bend the health care cost curve," those policies may not prove sufficient to put the national debt on a sustainable long-term path. And while the answer to this concern should not be indiscriminant cost-shifting, it does mean hard choices will have to be made – choices where the winners and winnings (including for future generations) roughly equal rather than greatly exceed the losers and losing.

Identifying the right "Savers" means thinking about how scarce federal health dollars should be allocated to do the most overall good. This is true in terms of the resources allocated to providers, beneficiaries, drug companies, and the states. Below, I discuss some of these options.

Reduce Medicare Provider Payments – up to $200 billion

The Medicare Payment Advisory Commission (MedPAC) and other experts have recommended that Medicare reduce or modify its payments to numerous providers who may be receiving excess subsidies under current law. For example, a number of bipartisan plans have recommended reducing payments to post-acute providers (home health agencies, skilled nursing facilities, etc.), with the FY 2015 President's Budget calling for nearly $80 billion of savings in that area over the next decade. Many proposals have also reduced or reformed reimbursements for unpaid beneficiary cost-sharing known as "bad debts," payments to hospitals who hire medical residents (graduate medical education), and rural hospitals that currently receive higher payments than their urban counterparts. In addition, a number of plans have called for reducing payments to Medicare Advantage plans in a variety of ways.

Extend and Increase Income-Related Medicare Premiums – $25 billion to $100 billion

Currently, most beneficiaries pay a premium roughly equal to 25 percent of per-beneficiary Medicare Part B and Part D costs, while high-income seniors – those in the top 5 percent – pay anywhere from 35 to 80 percent. The income thresholds for these higher premiums are currently frozen through 2019 but will jump to a much higher level in 2020. Simply continuing the freeze under current law would save $25 billion through 2024. The President's budget also proposed increasing income-related premiums to as high as 90 percent, saving another $25 billion. Lowering the thresholds to require closer to 20 percent of seniors to pay income-related premiums could push that total to as high as $100 billion.

To get a sense of the total amount of money that can be saved from increasing premiums, raising the base premium from 25 to 35 percent of program costs along with expanded income-relating premiums could save as much as $350 billion over ten years. However, few bipartisan discussions I've been involved with or am aware of would pursue that magnitude of an increase for that broad of the Medicare population.

Require Rebates to Reduce Federal Drug Payments – up to $170 billion

Currently, the federal government pays a reduced rate on prescription drugs purchased through the Medicaid program by requiring manufacturer rebates. In order to reduce federal spending on drugs, a number of proposals would expand these rebates and/or apply them within Medicare Part D. For example, the President's budget would strengthen the Medicaid rebate ($8 billion), expand it to LIS- and dual-eligible Part D beneficiaries ($116 billion), and accelerate rebates being provided as the Medicare "donut hole" is being closed ($17 billion). The Simpson-Bowles plan includes a more modest proposal to expand the existing Medicaid rebates only to those who are dually-eligible for Medicare Part D and Medicaid – effectively restoring the rebate those beneficiaries would have received prior to the creation of Medicare Part D.

Policymakers have a wide array of options as it relates to drug rebates within Medicare Part D. Not only can they dial the level of the rebate, but they can apply them to name brand drugs, generic drugs, or both; and they can apply them to dual-eligibles, dual-eligibles and the LIS population, or the entire Part D population.

Restrict the Ability of States to inflate their Medicaid Match – $10 billion to $60 billion ($10 billion)

States are currently able to inflate their claimed Medicaid costs by taxing health providers in order to distribute that money right back to providers and then receive a federal match on that distribution. This deceptive practice allows states to effectively pay providers one amount, but report a different higher amount to the federal government in order to receive larger federal payments. Provider taxes are currently limited to 6 percent of net patient revenue under current law, up from 5.5 percent as recently as 2011. To offset the costs of the Medicaid extenders, the PREP Plan would restore the limit to 5.5 percent. However, there is a good case to go much further. In 2011 and 2012, President Obama proposed limiting the practice to 3.5 percent of revenue. Simpson-Bowles prohibited the provider tax altogether, though it proposed enacting this restriction extremely gradually to give states time to plan and adjust. In addition to the provider tax scam, states employ a number of other "creative financing" techniques, including Intragovernmental Transfers (IGTs), that are worth investigating and clamping down on.

Importantly, any of these changes will by definition reduce the total federal dollars being spent on the Medicaid program that insures low-income beneficiaries. However, with debt rising unsustainably and health care cost control of central importance, it is at least worth questioning whether states should be rewarded for tricking the federal government into paying them more than the law intends.

Reduce Medicaid Payments to States – Dialable

Policymakers might also consider more directly requiring states to take more responsibility for their own health care costs. This could be done by reducing the Federal Medical Assistance Percentages (FMAP) that currently go to the states, doing so for only some types of payments (for example, those related to administrative expenses), reducing the current floor on FMAP payments, or even combining various matching streams into a single "blended rate" as was proposed by President Obama in 2011 and 2012.

Whether the federal government is seeking savings or not, it might be time to consider reforming the FMAP formula, which is quite complicated and may not reflect the best way to allocate resources among

states. One option would be to establish a commission to study the current formula and recommend a new formula that could either be budget-neutral or budget-reducing, depending on what Congress desires.

Reduce ACA Subsidies – Dialable

Currently, the ACA offers sliding scale insurance subsidies for people earning up to 400 percent of the poverty line, benchmarked to the second-lowest "silver plan" in each exchange. These subsidies could be reduced or modified in a number of ways. For example, subsidies could be benchmarked to "bronze plans" instead of silver, or they could be limited to those with income at 350 or 300 percent of the poverty line – the latter of which CBO estimates would save well over $100 billion.

With An Aging Population, We Can't Fix Our Debt with Health Reform Alone

As mentioned earlier, the largest driver of entitlement cost growth over the next quarter century – and even the growth of Medicare and Medicaid alone – is not health care cost growth but population aging. Since the year 2000, the number of individuals above age 65 has increased from 35 million to 45 million, and that number is projected to reach 80 million by 2035. The combination of the retirement of the large baby boom population and growing life expectancy also means that the above 75 population will double between now and 2035, from 20 to 41 million.[29] Meanwhile, birthrates will fail to keep up, resulting in a much older population.

The aging of the population will have a number of important fiscal and economic implications. At the same time the growing senior population drives up the growth of Social Security and Medicare spending, the relatively stagnant working population will hold down the growth in revenue collection. Meanwhile, lack of growth in the labor force and net withdrawals from savings and investment accounts will likely slow overall economic growth.

Given the substantial role population aging will play in increasing the country's debt-to-GDP ratio, it is unlikely that health-related solutions alone will suffice to put the debt on a sustainable long-term path. Instead, policymakers will need to supplement health reform with reforms aimed at mitigating the effects of population aging and cutting spending or increasing revenue elsewhere in the budget.

The effects of population aging can be mitigated in a few ways. To the extent Social Security and Medicare costs are growing because they will be providing benefits for more years, increases in the Social Security and Medicare retirement ages can help limit that growth. More fundamentally, changes to those ages, the Social Security Earliest Eligibility Age, and other age signals throughout the budget and tax code can help encourage individuals to work longer and thus put younger seniors back on the better side of the dependency ratio.

Thoughtful immigration reforms can also help to mitigate or at least smooth the effects of an aging population by bringing new younger workers into the economy and onto the tax rolls. Other changes designed to encourage work, investment, or higher productivity can also offset some of the effects of population aging. In particular, comprehensive tax reform can do all of those things, while also making us more competitive internationally, improving fairness, and reducing tax compliance costs.

[29] See Congressional Budget Office, "The 2014 Long-Term Budget Outlook," July 2014. http://www.cbo.gov/publication/45471

At the same time, none of these efforts will be enough to *stop* the effects of population aging. Therefore, health reform and "aging reform" will have to be accompanied by cuts in projected spending, increases in revenue, or some combination of the two.

Since discretionary spending has already been cut substantially both through the Budget Control Act and the sequester, net spending cuts in my view should focus exclusively on the mandatory side of the budget. Of course, the largest and fastest growing part of the non-health mandatory budget is Social Security, which has risen in cost from about 4 percent of GDP in 2007 to 5 percent today and will exceed 6 percent by 2030 – just before its trust fund runs out of money. Policymakers should pursue comprehensive Social Security reform that avoids a 23 percent across-the-board cut set to occur under current law and makes that program solvent for 75 years and beyond; as an important side effect, Social Security reform will slow the national debt as CBO projects it.[30]

Outside of Social Security reform, the biggest bucket of potential savings may very well be on the revenue side, where we currently spend $1.2 trillion per year on tax breaks that are in many cases expensive, regressive, and economically distorting. Tax reform could substantially cut back on tax expenditure, use most of the revenue to reduce tax rates, and leave a small portion for debt reduction.[31] Alternatively, policymakers might enact revenue-neutral or even revenue-reducing income tax reform, accompanied by an increase in the Medicare tax or the establishment of some new source of revenue.

Conclusion

With debt at record highs and on an unsustainable long-term path, there is no silver bullet to bring it back down. Policymakers will need to pursue a combination of spending cuts, new revenues, Social Security reform, an economic growth plan, and *especially* a strategy to reinforce and continue the recent slowdown in health care costs.

Over the next couple of years, divided government will force Democrats and Republicans to work together. Fortunately, there are a huge number of sensible health reform options that have or could garner broad bipartisan support.

Congress and the President should start first with the "Benders" – those policies that could truly reduce the structural growth of Medicare and other federal health spending. They should also pursue the "Savers" to make sure that every health dollar is being allocated in the best way possible. And they should continue to work together to test and enact new ideas that move us toward the goal of moving to a better health system at a better price – a health system that works for its beneficiaries, those who pay for it, and future generations of Americans who are counting on us to keep the federal debt under control.

Thank you for allowing me to testify on this important topic.

[30] See CRFB's "The Reformer" simulator at http://www.socialsecurityreformer.org which allows users to create their own Social Security plan and shows the effect on program cash flows and solvency.
[31] Read CRFB, "Tax Reform: Reducing Tax Rates and the Deficit," October 2012. http://crfb.org/document/report-tax-reform-reducing-tax-rates-and-deficit