Let's Get Specific: Health Care
September 2010

The *Let's Get Specific* series is intended to help focus the national discussion on specific policies that could help to reduce the deficit and create a better understanding of the types of policy changes that will be required. The policies recommended in this series are not necessarily endorsed by all the members of the Board of the Committee for a Responsible Federal Budget.

Fig. 1: Summary of Recommendations

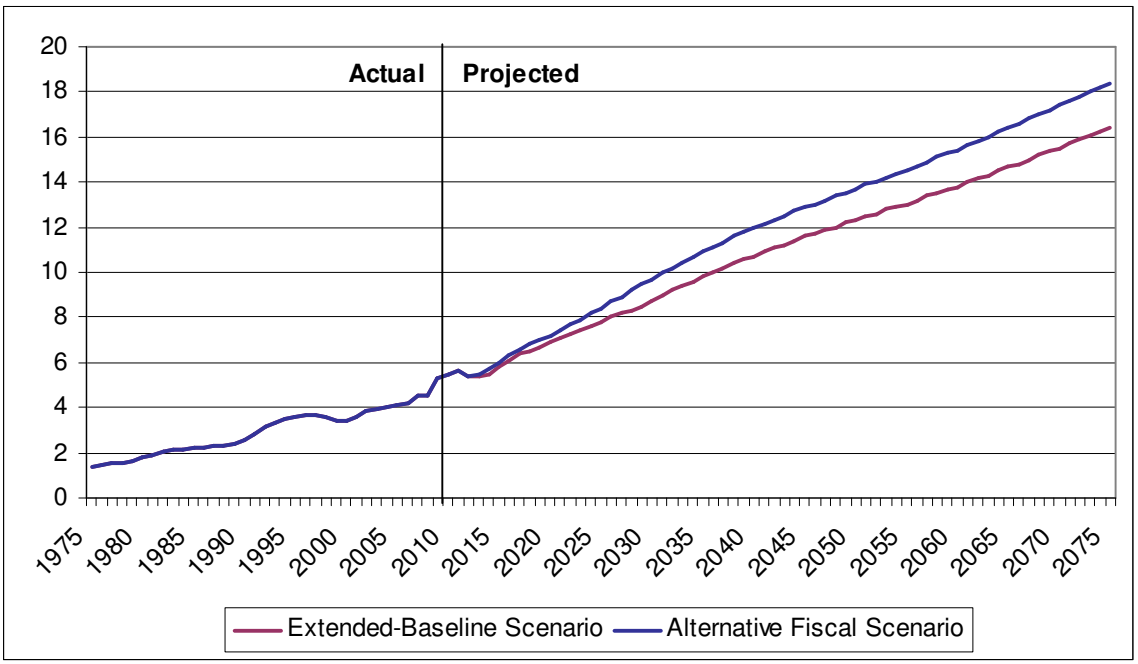
Short-Term Policies	10-Year Savings ($Billions)
Increase Cost-Sharing	$150
Enact Medicare Malpractice Liability Reform	$60
Limit Tax Exclusion on Employer-Provided Health Care	$250
Increase Medicare Eligibility Age to 67	$60[1]
Strengthen the Independent Payment Advisory Board (IPAB)	$30
Creating a Health Care Budget OR Introducing Premium Support	N/A
TOTAL SAVINGS	**$550**

The continued growth of federal health programs represents the single largest threat to the nation's fiscal health. By 2015, Medicare, Medicaid, exchange subsidies, and other federal health spending will reach 6 percent of GDP under CBO's Alternative Fiscal Scenario. The revenue loss from the tax exclusion on employer-provided health care will equal another 1.3 percent of GDP. And these costs will only grow. The Congressional Budget Office projects direct federal health care costs will total 9.7 percent of GDP by 2030, and 13.7 by 2050.

Two factors are responsible for this projected growth. First, the population is aging as a result of growing life expectancy and the retirement of the baby boom generation. This will increase the number of retirees collecting Medicare and long-term care benefits under Medicaid. Second and more importantly, overall health care costs are projected to grow significantly faster than the economy, resulting in a large increase in per-person health care costs—not only in the private sector but for public insurance programs as well.

While the recent health reform legislation is projected to result in lower deficits this decade and has the potential to slow economy-wide health care cost growth over time, it used almost all of the "low hanging fruit" in Medicare to finance a large new entitlement program. While there is significant disagreement over whether the reforms were worth the cost, there is little disagreement that more will have to be done. Over the longer run, the nation will need to come to grips with the reality that we cannot continue to enjoy unlimited access to an ever-growing (and increasingly advanced and costly) set of health care services.

Fig. 2: Projections of Federal Health Care Costs (percent of GDP)



Source: Congressional Budget Office.
Note: The health care projections in CBO's 2010 Long Term Outlook do not include offsetting receipts.

Recommendations

There is a number of common-sense reforms that could help reduce federal health spending that were either partially addressed or not addressed at all in the Affordable Care Act.

[1] CBO estimates suggest this option would have saved more than $100 billion before the enactment of the Affordable Care Act. We assume that, in light of health reform, about 40 percent of that money would be spent on Medicaid spending and exchange subsidies for individuals between age 65 and 67. Savings from this option would also grow significantly over the long-run, to perhaps as large as 0.3% of GDP.

Increase Cost Sharing

One area of potential savings that health care reform did not tap was beneficiary cost-sharing—in fact the legislation had the effect of reducing cost-sharing. Increasing deductibles, coinsurance, and copayments can help control costs in at least two ways – by shifting costs from the taxpayer to beneficiaries, and by making beneficiaries more cost-sensitive and therefore more selective in usage of care. This in turn slows health care cost growth by reducing utilization and exerting downward pressure on prices.

We recommend overhauling the hodge-podge of cost-sharing rules under Medicare and replacing them with a unified deductable and coinsurance, with a catastrophic limit. This strategy would not only discourage the overuse of medical services but – as compared to copays – it would encourage enrollees to compare relative costs. Through the catastrophic limit, it also would offer new protections to prevent out-of-pocket costs from getting too high. Comparative effectiveness and provider quality research could be better disseminated in order to give individuals more information about the providers and procedures they were choosing.

To ensure beneficiaries don't offset the effects of increased cost-sharing by purchasing wrap-around Medigap plans to cover such expenses, these supplemental plans should also be restricted. The vast majority of seniors currently hold "Medigap" plans, many of which already cover much or all of Medicare's cost-sharing requirements. To address this, we recommend limiting the extent to which Medigap providers are allowed to offer plans which cover the cost of deductibles or coinsurance.

Outside of Medicare, we also support giving plans in the new health exchanges more flexibility to increase cost-sharing for low-value services, and expanding the ability of States to introduce small and affordable copays for certain medical services in Medicaid.

Enact Medical Malpractice Liability Reform

Though it is certainly not the main driver of health care cost growth, our broken tort system drives costs higher than they should be. Currently, the direct costs of malpractice liability—including malpractice insurance premiums, settlements, awards, and administrative costs—equal about 2 percent of health expenditures. More significantly, the current system encourages "defensive medicine," where providers order unnecessary medical services in order to avoid possible lawsuits. By giving providers and insurers more certainty, we can reduce both the direct and indirect costs of the tort system without significantly hurting overall health outcomes.

We recommend creating "health courts" made up of expert jurors who can better rule on whether a physician is liable for an injury, the extent to which he or she did or didn't follow best practices, and the appropriate award for a given injury. We also support a number of other reforms such as limiting a defendant's liability to his or her share of the responsibility (a "fair-share rule"), putting a stricter statute of limitations on injury cases, and allowing courts to consider outside sources of support such as health and life insurance or workers' compensation in determining the cost of an injury (and therefore size of an award) to the plaintiff. Finally, we believe it is time to consider caps on punitive and non-economic damages. These caps reduce costs where they exist, and they add an amount of fairness and certainty to the system.

Limit the Tax Exclusion on Employer-Provided Health Care

Nearly every economist from across the political spectrum believes we need to address the tax excludability of health care. By exempting compensation in the form of employer-paid health insurance premiums from taxation, we are encouraging the purchase of more expensive health insurance plans and therefore driving up health care costs. The employer health exclusion is regressive, distortionary, and costs us over $200 billion a year in lost revenue.

The Affordable Care Act took an important first step by imposing a "Cadillac tax" on high-cost insurance plans, but it did not go nearly far enough. That tax does not take effect until 2018, and it does nothing to reduce the tax subsidy on plans below the "Cadillac" level.

We believe the exclusion eventually should be eliminated. However, understanding the importance of this exclusion both to the health system and to individuals, we would make changes gradually – and would not begin until the health exchanges (and the subsidies) are in place in 2014.

By 2015, our recommendation would be to completely eliminate the exclusion for high earners, and to begin limiting the size of the exclusion for others. Alternatively, the exclusion could be replaced with a smaller credit or deduction. Depending on the precise details of the reform, it may or may not make sense to modify the "Cadillac tax" scheduled to begin in 2018.

As the exclusion is phased out, we also recommend that the mandate for employers to offer health insurance and other rules to keep people in their current health plans also should be phased out (though the individual mandate should remain in place). The goal would be to make it easy for individuals – and employers for that matter – to purchase

insurance in the health exchanges where lower-earners could continue to receive a government subsidy.

Increase the Medicare Eligibility Age

The reforms described above are aimed at slowing health care cost growth, as they reduce the deficit. This option would help address the other main cause of growing federal health care costs – the aging population. Next year, the first retired baby boomers will become eligible for Medicare, and as that cohort ages, costs will rise significantly. Even after the baby boomers all reach retirement, growing life expectancy will continue to drive up costs by increasing the number of Medicare-eligible individuals.

As people live longer, it only seems logical to raise the Medicare age. The Social Security retirement age already has increased from 65 to 66, and is scheduled to rise to 67 by 2027. We think the Medicare age should be brought up to the same level, and then indexed to growing longevity (we also think the Social Security retirement age should be indexed to longevity, but that is a discussion for another paper). In addition to reducing Medicare costs, increasing the eligibility age will encourage some individuals to work longer – which will help support faster economic growth and increase income tax revenue. Because of the newly created exchanges, those who retire before age 67 (or do not have access to employer-provided coverage) will be able to purchase insurance through the exchanges with the progressive subsidies and "age rating" restrictions which forbid insurance companies to charge excessive premiums (more than 3 to 1) based on age.

Strengthen IPAB

One of the most promising features of the Affordable Care Act was the establishment of the Independent Payment Advisory Board (IPAB), which is required to recommend Medicare payment cuts when costs grow too quickly, and whose recommendations are automatically enacted if not overruled by Congress. However, IPAB's jurisdiction is quite limited. We therefore recommend significantly expanding its purview. First, we would eliminate the temporary exemptions in place for hospitals, skilled nursing facilities, and other exempted providers. We would also give IPAB power over Disproportionate Share Hospital (DSH) payments to hospitals that treat high numbers of uninsured patients, and over indirect and graduate medical education. In addition, we would allow IPAB to expand the current payment reform pilot or demonstration projects if they appeared to be working – even before their test periods have finished.

Most experts would probably agree with those changes, yet we would go further. IPAB's authority also should be expanded to encompass cost-sharing and benefit design. The board could be particularly useful in increasing cost-sharing on low-value care. In addition, IPAB should be given the authority to make changes to Medicaid, CHIP, the health insurance exchanges, and perhaps even the employer health exclusion.

We believe these changes will not only improve the chances that IPAB will succeed in achieving its projected savings, but will allow it to go beyond its current targets. We would therefore increase IPAB's targets by $10 billion a year beginning in 2017, and modify its rules so that failure to adapt its recommendations (or fiscally equivalent ones) would result in an across the board cut in provider payments and increase in beneficiary premiums.

Fig. 3: Details of Short-Term Reforms

Increase Cost Sharing in Federal Programs • Replace Medicare's cost-sharing requirements with a unified deductible and a uniform coinsurance rate with a catastrophic limit • Impose additional cost sharing requirements on low value care • Restrict Medigap plans to limit their coverage of Medicare cost-sharing • Allow states more flexibility in imposing nominal copays in Medicaid
Enact Medical Malpractice Liability Reform • Establish "medical courts" of expert panelist to determine malpractice cases • Create a "fair share rule" to limit the liability of a defendant to his share of responsibility for an injury • Allow income from insurance, worker's compensation, and other sources to be considered when deciding the size of an award • Impose caps on both non-economic and punitive damages
Limit Employer-Provide Health Care Tax Exclusion • Phase-out the tax exclusion on high earners completely by 2015 • Once the exchange is set up, in 2014, cap the size of the tax exclusion for others • Alternatively, replace the exclusion with a flat credit or deduction • Over time, phase out exclusion altogether and encourage individuals to purchase insurance through the health exchange
Increase Medicare Eligibility Age • Gradually increase the Medicare eligibility age from 65 to 67 once the exchanges are in place • Index the Medicare eligibility age to longevity once it reaches 67
Strengthen the Medicare Independent Payment Advisory Board • Cancel the temporary IPAB exemptions given to hospitals and other providers • Expand IPAB's authority to implement the payment reforms currently being piloted • Allow IPAB to make changes to cost-sharing and benefits design • Give IPAB authority to make changes to Medicare, CHIP, and exchange subsidies • Require IPAB to find an additional $10 billion in savings per year from 2018 on, and create a sequester which cuts provider payments and increases beneficiary premiums across the board if IPAB (or deficit-neutral) proposals are not adopted

Continued Long-Run Cost Control

Even after these reforms, more will have to be done in the long-run. These changes will have to involve putting hard constraints on federal health spending. For Medicare and Medicaid, we ultimately see two options—putting the programs into a budget or transforming them (or at least Medicare) into premium support systems. Both approaches would limit the amount of health care individuals could receive in order to prevent cost growth from bankrupting the country – the former through government decisions and the latter through market forces. In a world of limited resources, such constraints are ultimately necessary; the only question is how.

A Budget for Medicare and Medicaid

The most direct way to control the growth of Medicare and Medicaid would be to put them in a budget. This idea may seem radical, since we are so used to seeing these programs as open-ended entitlements. Yet other countries commonly rely on budgetary limits to control their health care spending, and so too must we.

Since people count on Medicare as a component of their retirement income, a long-term budget makes sense – perhaps one which looks 25 years into the future and is reviewed every five years. At each review period, Congress would decide on an appropriate growth rate and make changes projected to achieve the proposed targets. IPAB could be allowed to make adjustments to ensure targets are met between budget reviews, though they should be given directions regarding what levers to focus on.

Selecting the appropriate growth rate ultimately must be a political decision in which policymakers weigh spending on Medicare and Medicaid against other spending and revenue priorities. We think that allowing the budget to grow one percentage point faster than the economy probably makes sense on average, though the growth rate may need to be somewhat higher as the baby boomers enter retirement, and will eventually need to fall to at or below the growth rate of the economy to ensure long-run sustainability.

Budgetary constraints could be a powerful tool in encouraging efficiency, including through many of the policies we suggested above. Ultimately, though, policymakers would likely need to rely on the four unpopular choices of reducing provider payments, increasing premiums, expanding cost-sharing, and rationing care. And given the inevitable limits of the first three choices, rationing would probably become an increasingly important tool over time.

A Premium Support System

As an alternative to an overall budget, policymakers could transform Medicare—and possibly Medicaid into a premium support system. Under this system, the government would contribute a fixed amount to beneficiaries each year, which could be used to purchase Medicare through either the traditional fee-for-service program or through a private insurer.[2]

We should note that such a design would not avoid the hard decisions—to lower provider payments, increase premiums, expand cost sharing, and ration care—which we identified in the previous alternative. Rather, this system would turn some of those decisions over to the marketplace.

In theory, Medicaid could also be transformed into a premium support system. Given the involvement of the states in the program, though, it might make more sense to simply give the states more flexibility in managing their Medicaid programs, and then putting a cap on the per person subsidy the federal government would offer.

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[2] In principle, a premium support system could be designed in any number of ways, but the basic framework is always the same. The government sets a fixed "benchmark" for premiums and contributes a fixed amount per beneficiary (say 75 percent of that benchmark) toward those premiums; then private plans compete with each other and with traditional Medicare to win over customers. If plans come in above the government benchmark, the entirety of the excess premium is born by the purchaser; if plans come in below the benchmark, they can charge a lower overall premium – though we believe a portion of the savings (say 25 percent) should accrue back to the government.

A key question in designing a premium support system is how to set the benchmarks. Broadly speaking, the choices are to set benchmarks annually based on competitive bidding or to decide on fixed contributions in advance. We recommend a hybrid approach in which bidding is used to set the initial benchmarks and encourage continued price competition, but a maximum contribution is set as a failsafe should competitive bidding fail to hold down costs. This approach is similar to one proposed by President Clinton for the broader health care system – "managed competition within a budget."

We suggest setting benchmarks at the average bid in each location, initially, and reducing benchmarks over time to half way between the lowest bid in their area and the average national bid. That approach would allow only the most efficient insurers to charge lower premiums and would help to depress wide geographical variations in costs. As a failsafe, we recommend restricting growth in the size of these benchmarks to 1 percent above GDP (which would effectively restrict overall Medicare growth to GDP + 1 percent +increases in the Medicare population).

IPAB's expanded authority would help give Medicare's traditional fee-for-service program more flexibility to compete with private firms, and this added level of competition might work to further drive down costs.

Other Possible Reform Options

The reform options outlined above are not intended to be an exhaustive list. Other options include creating a "public option" or a government-run health-care company akin to Medicare and Medicaid, which would allow the government greater control over overall costs. Another option would be to directly increase Medicare premiums – either across the board or for certain individuals. Though this would do little, if anything, to control overall health care costs, it would shift some of the burden away from the taxpayer and toward the Medicare beneficiary.

Conclusion

The last round of health care reform was a politically grueling process and many people would like to shelve the issue for the time being. Unfortunately, health care cost growth continues to present the single largest threat to the country's fiscal future. Additional changes will have to be made and the less that is done to control health costs, the more that will have to come out of other areas of the budget.