



Statement before the Senate Committee on the Budget

Containing Health Care Costs: Recent Progress and Remaining Challenges

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Chairman Murray, Senator Sessions, and other members of the committee, thank you for the opportunity to testify today before the Senate Committee on the Budget.

The recent slowdown in the growth of health spending has raised hopes that the health system may have shifted to a “new normal,” with costs that are more affordable and sustainable for the future. Although private health plans and providers have adopted promising reforms over the past decade, the evidence strongly indicates that health spending growth will rebound as we return to a full-employment economy. Growth rates for health spending might not return to the high levels that we have seen in past decades, but they will rise substantially.

Rising health care costs will have serious consequences for the federal budget. The Congressional Budget Office (CBO) projects that entitlement spending will crowd out other budget priorities over the next decade and beyond, with growth in health programs outstripping other major categories of federal spending.¹ Health spending—Medicare, Medicaid, CHIP, and exchange subsidies—is projected to grow by 33 percent between 2012 and 2022 under current law.² Other programs (excluding Social Security) will see their budgets decline by 37 percent. Only interest on the federal debt will grow faster than health spending, increasing by about 80 percent over the decade.

The Affordable Care Act (ACA) will substantially increase national health spending through new subsidies for Medicaid and insurance purchased on the exchanges. The law includes provisions to reduce Medicare payment rates to providers and Medicare Advantage plans, expand bundled payments in traditional Medicare, and introduce accountable care organizations (ACOs). It is too early to know how effective those measures will be in slowing program spending, but the ACO initiative has already suffered a setback with the departure of 9 Pioneer ACOs from the program.

It is imperative that Congress develop a responsible budget plan that can begin to resolve the structural defects in federal health programs and subsidies for health insurance. The key to putting federal health spending on a sustainable path is market-based Medicare reform. By promoting effective competition and informed consumer engagement, we can fulfill our obligation to ensure that Medicare will be there for future retirees without imposing a prohibitive tax burden on future workers.

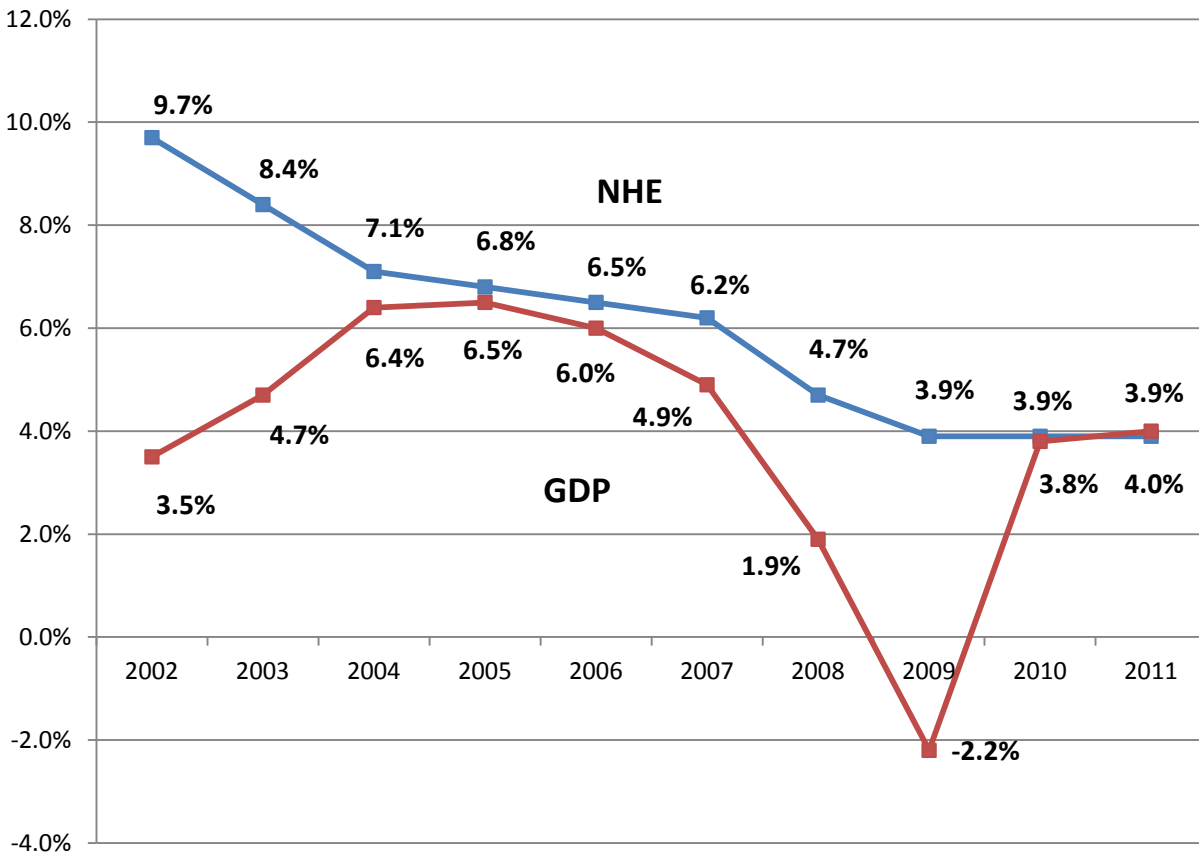
Will the Health Spending Slowdown Last?

With little fanfare until recently, the growth in national health spending has declined sharply over the past decade. Data from the Centers for Medicare and Medicaid Services (CMS) shows that growth in national health expenditures peaked in 2002, growing 9.7 percent in a year

¹ CBO, *The 2012 Long-Term Budget Outlook*, June 2012, <http://www.cbo.gov/publication/43288>.

² Author’s calculation of the increase or decrease in the share of each year’s GDP accounted for by each major program, based on Table 1-2 of CBO’s 2012 long-term budget outlook report, Extended Baseline Scenario.

Figure 1. Annual Growth Rates for National Health Spending and GDP



Source: CMS National Expenditure Accounts, Table 1, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf>.

that saw the economy grow by only 3.5 percent (Figure 1).³ Health spending growth dropped to 8.4 percent in 2003 and continued to decline until 2009 when the rate fell to 3.9 percent—and has remained at that rate for three consecutive years.

The biggest single factor driving the recent slowdown is the economy. The severe recession that began in December 2007 and ended in June 2009 had an immediate impact on health spending as workers lost their jobs and their health coverage. According to the CMS analysis, the decline in health insurance enrollment in 2009 was the largest one-year drop recorded in the National Health Accounts. The failure of the economy to bounce back as quickly as it has after past recessions has prolonged this dampening effect on health spending.

How much of the slowdown in health spending can be attributed to a weakened economy is uncertain. A study by the Kaiser Family Foundation and the Altarum Institute concludes that 77 percent of the recent decline in health spending growth can be explained by changes in the

³ Micah Hartman, Anne B. Martin, Joseph Benson, Aaron Catlin, and the National Health Expenditure Accounts Team, “National Health Spending In 2011: Overall Growth Remains Low, But Some Payers And Services Show Signs Of Acceleration,” *Health Affairs*, January 2013 32:87-99, <http://content.healthaffairs.org/content/32/1/87.full>.

broader economy, taking into account both changes in GDP growth and general price inflation.⁴ Cutler and Sahni find that the 2007-09 recession accounted for 37 percent of the slowdown between 2003 and 2012.⁵

Holahan and McMorrow point out that narrowly focusing on the recession ignores the impact of the economy on the declining growth rates for health spending that occurred before 2007.⁶ The early 2000s were a period of relatively slow economic growth compared to the 1990s (illustrated in Figure 1), and declines in family incomes and insurance coverage probably contributed to slowing health expenditures that occurred in the years after 2002. This evidence supports the Kaiser-Altarum finding that economic declines rather than structural changes in the health sector are primarily responsible for the slowdown in health spending over the past decade.

Slowing the growth of health spending because the economy is failing is obviously not desirable. Other factors also contributed to the decline, but they are clearly less significant and are not necessarily structural changes in the health system.

Fuchs observes that “some of the reasons for the slow growth in the past 2 years...are one-time gains, not alterations in such determinants of long-term growth as new medical technology and the aging of the population.”⁷ For example, over the past two years, major drug companies have lost exclusive rights to many billion-dollar selling drugs.⁸ The availability of lower-cost generic formulations reduces health spending, but does not change the fundamental drivers of health spending.

Changes in the health sector may have more persistent impacts on spending. Ryu and colleagues found that health plans offered by large firms became less generous over the last five years, resulting in increasing out-of-pocket costs for beneficiaries.⁹ Not surprisingly, when employees are responsible for more of the cost of health services, spending declines. Consumer-directed health insurance plans, which combine a high deductible with a health savings account and offer lower premiums than more traditional coverage, have gained a

⁴ Kaiser Family Foundation, “Assessing the Effects of the Economy on the Recent Slowdown in Health Spending,” April 22, 2013, <http://kff.org/health-costs/issue-brief/assessing-the-effects-of-the-economy-on-the-recent-slowdown-in-health-spending-2/>.

⁵ David M. Cutler and Nikhil R. Sahni, “If Slow Rate Of Health Care Spending Growth Persists, Projections May Be Off By \$770 Billion,” *Health Affairs*, May 2013 32:841-850, <http://content.healthaffairs.org/content/32/5/841.full>.

⁶ John Holahan and Stacey McMorrow, “What Drove the Recent Slowdown in Health Spending Growth and Can It Continue?” Urban Institute, May 6, 2013, <http://www.urban.org/url.cfm?renderforprint=1&ID=412814>

⁷ Victor R. Fuchs, “The Gross Domestic Product and Health Care Spending,” *New England Journal of Medicine*, 369:107-109, July 11, 2013, <http://www.nejm.org/doi/full/10.1056/NEJMp1305298>.

⁸ Rick Mullin, “Beyond The Patent Cliff,” *Chemical & Engineering News*, December 10, 2012, <http://cen.acs.org/articles/90/i50/Beyond-Patent-Cliff.html>; Katie Moisse, “10 Top-Selling Drugs Coming Off Patent,” ABC News, July 25, 2011, <http://abcnews.go.com/Health/Drugs/prescription-drug-prices-plummet/story?id=14152014>.

⁹ Alexander J. Ryu, Teresa B. Gibson, M. Richard McKellar, and Michael E. Chernew, “The Slowdown In Health Care Spending In 2009–11 Reflected Factors Other Than The Weak Economy And Thus May Persist,” *Health Affairs*, May 2013 32:835-840, <http://content.healthaffairs.org/content/32/5/835.full>.

growing share of the market in recent years. If this trend continues, that will help reduce the growth of health spending.¹⁰

Additional health system developments could also contribute to lower health spending growth into the future. The health care work force is changing, with more women becoming physicians and younger physicians seeking more stable work hours as employees of hospitals. The adoption of health information technology promises to reduce waste and improve care coordination, although that will only happen if payment and delivery systems change to take advantage of that potential. Care is beginning to move away from the doctor's office and into pharmacies, supermarkets, and shopping malls. Stronger competition among health plans, including those operating on the health insurance exchanges, will exert downward pressure on premiums.

These changes are promising, but there is no evidence that our health spending crisis has been resolved. Moreover, what has slowed in the past decade is the *growth* in health care spending, not the *level* of spending. Adjusting for inflation, health spending has increased an average of \$1,385 per person between 2002 and 2011.¹¹ National health spending has continued its upward climb, although at a slower rate than in the past.

How Much Did the ACA Contribute to the Slowdown?

The primary goal of the ACA was to increase health insurance coverage, not reduce health spending. Since the law was enacted years after the major decline in health spending growth, ACA provisions that could help to slow growth in the future had little impact on the reductions thus far. According to the CBO, the largest source of savings from reduced health spending is reductions in Medicare provider payment rates. Other proposals, including bundled payment and ACOs, intend to change the structure of the program in a more permanent way.

Reductions in Medicare payment rates for hospitals and other providers generate impressive budget savings as scored by the CBO. Cuts in payment rates alone do not change the financial incentives that promote greater use of services and cannot be considered a structural reform. If implemented, this policy generates a series of one-time savings that increase every year.

Congress is unlikely to allow the full amount of payment reductions for hospitals and other Part A providers required by the ACA to be implemented as scheduled. Medicare's Office of the Actuary reported that by 2019 those payment reductions would result in operating losses for 15 percent of hospitals, skilled nursing facilities, and home health agencies. By 2030, 25 percent of Part A providers would sustain losses, and by 2050 that number rises to 40 percent.¹²

¹⁰ Amelia M. Haviland, M. Susan Marquis, Roland D. McDevitt, and Neeraj Sood, "Growth Of Consumer-Directed Health Plans To One-Half Of All Employer-Sponsored Insurance Could Save \$57 Billion Annually," *Health Affairs*, May 2012 31:1009-10152, <http://content.healthaffairs.org/content/31/5/1009.full>.

¹¹ Author's calculation using data from the National Health Accounts and the chained CPI to estimate the change in spending deflated to 2002 dollars.

¹² John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under Illustrative Scenarios with Alternative Payment Updates to Medicare Providers," CMS Office of the Actuary, May 31, 2013,

The severity of these cuts was emphasized by Medicare's chief actuary in the 2013 Trustees report.¹³ He stated:

Medicare prices would be considerably below the current relative level of Medicaid prices, which have already led to access problems for Medicaid enrollees, and far below the levels paid by private health insurance. Well before that point, Congress would have to intervene to prevent the withdrawal of providers from the Medicare market and the severe problems with beneficiary access to care that would result. Overriding the productivity adjustments, as Congress has done repeatedly in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected under current law.

Other Medicare provisions can properly be considered structural reforms that could yield continuing savings, but they are partial measures at best. Bundled payments would expand the boundaries of inpatient payment to include hospital and associated physician and pre- and post-acute services. Bundling provides incentives for providers to economize in treating patients requiring inpatient stays, perhaps by eliminating unnecessary tests or doing a better job coordinating the delivery of services.

Bundling changes the unit of payment but it does not change fee-for-service incentives to expand volume. Any efficiencies that are gained are *micro* efficiencies, focused on the specific episode of care rather than on the entire spectrum of the patient's health care needs. The alternative is capitation, which pays a health plan a fixed amount for all the services provided to the patient. Under bundling Medicare would continue to pay on a piece rate basis, but with larger pieces.

ACOs attempt to create integrated networks of hospitals, physicians, and other providers in the context of traditional fee-for-service Medicare. ACO providers would continue to be paid fee-for-service, but would keep half of any savings compared with what the patient's care would have cost otherwise. High-performing ACOs would also be eligible for a bonus from CMS. Medicare beneficiaries would not formally enroll in an ACO, but their costs would be attributed to their primary physician if that doctor participates in an ACO. In that sense, an ACO is a virtual HMO that is intended to be invisible to the patient.

Supporters of the ACO concept point to earlier integrated systems, such as Geisinger Health Care in Pennsylvania and Intermountain Health Care in Utah, as evidence that ACOs can provide effective lower-cost care.¹⁴ That ignores the decades of development and innovation that made those health plans what they are today. Such capacity cannot be built overnight.

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2013TRAlternativeScenario.pdf>.

¹³ Paul Spitalnic, "Statement of Actuarial Opinion," Appendix J in The Boards of Trustees, *The 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, June 11, 2013, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2013.pdf>.

¹⁴ James Capretta, "The Predictable Failure of Medicare ACOs and a New Model That Would Actually Work," American Enterprise Institute, forthcoming.

To jumpstart the program, CMS created Pioneer ACOs for health care organizations and providers that were already operating as integrated systems.¹⁵ The program began operation in 2012 with 32 well-regarded organizations—including Partners Healthcare in Boston, Dartmouth Hitchcock in New Hampshire, and others—selected from a large applicant pool.¹⁶

On February 25, 2013, 30 of the Pioneer ACOs sent a letter to CMS complaining that 19 of the 31 quality standards required by the Administration had insufficient data to support their use, raising questions about the plans further participation in the program.¹⁷ In an unusual move, the plans threatened to leave the program if this problem was not resolved. CMS agreed to a compromise, averting the crisis.¹⁸

More bad news followed. On July 16, 2013, CMS announced results of the first year of Pioneer ACO operation.¹⁹ Only 13 of the Pioneers saved enough money to share those savings with Medicare, despite their experience as integrated health systems and additional investment in programs and staff to make the program work. Two Pioneer ACOs lost money, and owe the Medicare program \$4 million. To avoid possible future losses, 9 of the 32 Pioneer ACOs will leave the program.

The core problem was identified by Chas Roades, chief research officer at the Advisory Board Company, in a Kaiser Health News article.²⁰ He commented that “we should temper our expectations about how much money we’re actually going to save through ACOs.” From the viewpoint of the hospital, ACOs are an attempt to preserve the Medicare fee-for-service system and the ACO model only applies to a portion of their Medicare patients. Roades added that it is “really hard to run two disparate sets of books at the same time” with two different sets of financial incentives.

Other elements of the ACA might slow health spending. Beginning in 2018, high-cost insurance plans offered by employers would pay a 40 percent tax on the value of the plan that exceeds a threshold amount—initially \$10,200 for individuals and \$27,500 for family coverage. Although this policy is inferior to capping the tax exclusion on employer-sponsored coverage, it is likely to be effective in discouraging employers from offering “Cadillac” plans with very generous benefits. The shift to leaner plans with higher cost-sharing requirements would reduce

¹⁵ CMS, “Pioneer ACO Model,” undated (accessed July 28, 2013), <http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/>.

¹⁶ CMS, “Pioneer Accountable Care Organization Model: General Fact Sheet,” September 12, 2012, <http://innovation.cms.gov/Files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf>.

¹⁷ Pioneer ACO plans, Letter to Rick Gilfillan on quality standards for Pioneer ACOs, February 25, 2013, <http://www.washingtonpost.com/blogs/wonkblog/files/2013/03/2013-Quality-Benchmarks.pdf>; Jenny Gold, “A Bump In The Road To Accountable Care?” Kaiser Health News, March 8, 2013, <http://capsules.kaiserhealthnews.org/?p=17632>.

¹⁸ Nathaniel Weixel, “No Delay in Quality Accountability for Pioneer ACOs, but Metrics Will Change,” *BNA’s Health Care Policy Report*, April 29, 2013.

¹⁹ CMS, “Pioneer Accountable Care Organizations succeed in improving care, lowering costs,” July 16, 2013, <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-16.html>.

²⁰ Jenny Gold, “9 Pioneer ACOs Jump Ship After First Year,” Kaiser Health News, July 16, 2013, <http://capsules.kaiserhealthnews.org/?p=20879>.

health care utilization, but the four-year delay in implementation suggests that the provision may never be implemented.

These and other provisions intended to reduce federal health spending are secondary to expanding access to health insurance, the main objective of the ACA. Expanding Medicaid coverage and creating an insurance subsidy for those with incomes up to 400 percent of the federal poverty level could reduce the number of uninsured by 14 million next year, and by 2016 that number could rise to 25 million.²¹ About 10 percent of the under-65 population could become newly-insured as a result of the ACA—substantially adding to the demand for health services and driving up cost.

Some analysts argue that enhanced competition among health plans in the exchanges will reduce health spending.²² Enrollees are required to pay the full difference between the benchmark plan (which sets the individual's subsidy amount) and higher cost plans. That should lead to competition among the plans focused on price—the one element of health insurance that everyone can understand.

That is certainly the incentive of fixed-subsidy systems, including the premium support model advanced by Rep. Paul Ryan. The problem with the ACA model is that it sets the bar too high for health plans, requiring that they provide far richer benefits than consumers would purchase on their own. Low-income consumers would probably buy lower cost plans than available on the exchange if they were given the federal subsidy to spend as they please, keeping any extra payment to cover other essential expenses. Competition on the exchanges would lower insurance costs, but only after ACA requirements raised the cost level by 25 percent or more—and perhaps as much as two to three times more expensive than plans available on the market today.²³

The Medicare chief actuary estimated that the ACA would increase national health spending by \$311 billion between 2010 and 2019.²⁴ The estimate takes into account both the expansion of health coverage and the cost-reducing components of the ACA.

The longer-term impact on health spending depends on state decisions to expand Medicaid and Congress's willingness to enforce cost-reducing provisions in the ACA. Accounting for those factors, we estimate that national health spending will increase by about \$500 billion between 2014 and 2023 as a consequence of the law. Additional Federal health

²¹ CBO, "Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act—May 2013 Baseline," May 14, 2013, <http://www.cbo.gov/publication/44190>.

²² Stephen Zuckerman and John Holahan, "Despite Criticism, The Affordable Care Act Does Much to Contain Health Care Costs," Urban Institute, October 2012, <http://www.urban.org/UploadedPDF/412665-Despite-Criticism-The-Affordable-Care-Act-Does-Much-to-Contain-Health-Care-Cost.pdf>.

²³ Louise Radnofsky, "Health-Insurance Costs Set for a Jolt," *Wall Street Journal*, June 30, 2013, <http://online.wsj.com/article/SB10001424127887324251504578577760224985382.html>; Joseph Antos, "Would You Buy Insurance From This Man?" *Daily Caller*, July 18, 2013, <http://dailycaller.com/2013/07/18/would-you-buy-insurance-from-this-man/>.

²⁴ Richard S. Foster, "The Estimated Effect of the Affordable Care Act on Medicare and Medicaid Outlays and Total National Health Care Expenditures," Testimony before the House Committee on the Budget, January 26, 2011, <http://budget.house.gov/uploadedfiles/fostertestimony1262011.pdf>.

spending will exceed that amount, which nets out lower spending for health care by individual consumers and employers. This higher level of federal spending caused by the ACA further strains government's ability to finance existing health programs and still have the resources to advance other domestic and international policy priorities.

A Sustainable Budget

The rising cost of entitlement programs will put increasing pressure on the budget unless action is taken. According to CBO long-term projections, federal spending for Medicare, Medicaid, CHIP, and exchange subsidies will increase 33 percent between 2012 and 2022 under current law.²⁵ Social Security is projected to grow about 8 percent over that period. Other federal programs will shrink by about 38 percent.

We clearly need to rebalance our spending priorities. Medicare is the place to start.

Medicare spending will nearly double over the next decade, increasing from \$586 billion this year to more than \$1 trillion in 2023.²⁶ The oldest members of the baby boom generation have reached age 65 and are enrolled in Medicare. Over the next two decades, some 76 million people will move out of the workforce, into retirement, and into Medicare. That will place an increasing burden on the budget and on younger generations whose taxes support the program.

The uncapped entitlement and distorted fee-for-service structure of traditional Medicare are major causes of the rapid rise in program spending. Poorly targeted fee-for-service payments promote the use of more—and more expensive—services, delivered in a fragmented and uncoordinated environment. The result has been higher spending and poorer patient outcomes.

Converting Medicare to a defined contribution model, with beneficiaries given a choice of competing health plans including traditional Medicare, would change the incentives that drive program spending. In general terms, this is the principle behind the ACA's subsidies in the health insurance exchanges. Seniors choosing a more expensive plan would pay any extra premium out of their own money. Informed consumer choice will create competition among the plans that will help to lower costs.

For this competitive model to work, traditional Medicare must be modernized. The program's benefit structure is needlessly complicated and should be simplified. The separate deductibles for inpatient services under Part A and for physician and outpatient services under Part B should be combined. The confusing array of copayments, coinsurance, and limitations on payments for services should be replaced with an easily-understood schedule of cost-sharing requirements. Coverage for catastrophic expenses should be added as a core benefit.

Medicare's physician payment system should be reformed. After a decade of overriding the reductions required by the Sustainable Growth Rate (SGR) formula, it is time for Congress to

²⁵ Author's calculation of the increase or decrease in the share of each year's GDP accounted for by each major program, based on Table 1-2 of CBO's 2012 long-term budget outlook report, Extended Baseline Scenario. See CBO, *The 2012 Long-Term Budget Outlook*.

²⁶ Congressional Budget Office, *Medicare—May 2013 Baseline*, <http://www.cbo.gov/publication/44205>.

permanently resolve this ongoing problem. Bipartisan legislation in the House would replace the 25 percent payment rate reduction that would otherwise be imposed in January with annual payment increases of 0.5% until 2019. A new Physician Quality Reporting Program would reward high-performing physicians with bonuses.

The CBO estimates that the cost of a permanent SGR fix is \$138 billion over the next decade. The House bill does not specify how the government would cover that cost, but payment offsets will be part of any legislation that is agreed to by Congress. The Medicare Payment Advisory Commission (MedPAC) has suggested a framework that strikes a balance between the total cost of repealing the SGR and the need to ensure beneficiary access to care.²⁷ That could be the starting point for reaching agreement on a long-overdue reform.

Congress will be tempted to stop its work on Medicare after it finds the savings to pay for the SGR fix. That would be a mistake.

There is broad agreement that Medicare spending is on an unsustainable trajectory that threatens to crowd out other priorities elsewhere in the budget. There is broad agreement that Medicare's performance in delivering services to older Americans can and should be improved. There is great controversy over how to ensure that seniors continue to receive high-value health care at a price that is affordable to them and to taxpayers.

Small-bore policies, such as those recommended by MedPAC to pay for the SGR fix, yield scoreable budget savings. Those types of policies are the bread and butter of this Committee and its counterpart in the House. They are necessary, but they are not enough.

If we want to bend Medicare's cost curve, we must change the financial incentives that drive program spending to increasingly unaffordable levels. A well-designed premium support program can take full advantage of market competition to drive out unnecessary spending and increase Medicare's value to beneficiaries. This is a safe and reasonable approach to lowering program costs over the long term without imposing undue sacrifice on seniors or taxpayers. It is also our best hope for real Medicare reform.

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²⁷ MedPAC, "Moving forward from the Sustainable Growth Rate (SGR) System," Appendix B in *Report to the Congress: Medicare Payment Policy*, March 2013, http://www.medpac.gov/chapters/Mar13_AppB.pdf.