Testimony Presented to the Senate Budget Committee:

"Putting Health Care Spending on a Sustainable Path"

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February 29, 2012

Mr. Chairman, Ranking Member Sessions, and members of the committee, thank you for the opportunity to participate in this very important hearing on "Putting Health Care Spending on a Sustainable Path."

It is a particular pleasure for me to appear before you today as a witness because I worked for this committee for a decade as one of the staff members when Senator Domenici served as Chairman and Ranking Member.

I will make three basic points in my testimony today:

1. Rapidly rising entitlement spending is the cause of our nation's fiscal problems, and escalating health costs is the primary reason for the entitlement spending surge.

2. The health care law that passed in 2010 has made the fiscal problem much worse because it used Medicare cuts and taxes to increase non-Medicare entitlement spending *and* pay future Medicare benefits. Further, the Medicare

cuts are very unlikely to be sustained over the long term anyway.

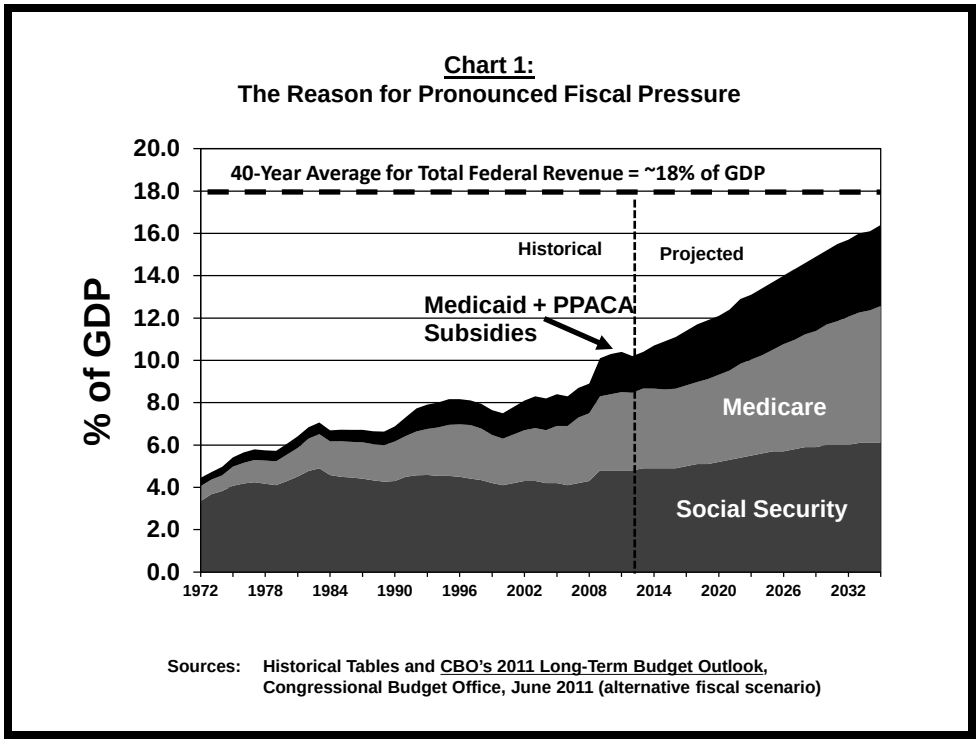
3. Putting health spending on a sustainable path requires significant Medicare reform, but the federal government can't "engineer" this reform through regulations, demonstrations, and micromanagement. The answer is a functioning and dynamic marketplace.

The Reason for Pronounced Fiscal Pressure

It is sometimes argued that the reason we have budget problems today is because of discrete tax or spending decisions made over the last decade or so. But this line of argument relies on what might be called the fallacy of the uncontrolled baseline. It gives a pass to the massive run-up in spending due to the growth in entitlements, and especially health care entitlements, and tries to assign all of the blame for our fiscal woes to tax policies that have held tax collection at about the historical post-war norm for the United States.

But, as shown in Chart 1, a longer-term perspective clearly indicates that entitlements are the problem, and most especially the health care entitlements. Over the past forty years, federal tax collection has averaged about 18 percent of GDP annually. Meanwhile, back in 1972, the federal government spent 4.4 percent of GDP on the big three entitlement programs, Social Security, Medicare, and Medicaid. So there was plenty of revenue left over after covering the costs of these entitlements for other governmental

priorities.



Today, spending on just those three programs is expected to reach 10.2 percent of GDP, according to the Congressional Budget Office (CBO). So, in other words, today the government is spending an additional 6 percentage points of GDP on just these three programs compared to 1972. To put that in perspective, spending on defense and other security-related functions of the government totals only 5.6 percent of GDP in 2012.

This trend toward devoting more and more resources to entitlements is only going to accelerate as the baby boom retires. Over the next twenty-five years, CBO expects spending on these programs, plus the new entitlements created in the health care law, to push total spending on these programs over 16 percent of GDP, with reasonable

assumptions about the growth in provider payments and other factors. If that were to occur, there would be virtually no room left in the budget for anything else, assuming the historical level of tax collection.

The Health Law Makes the Budget Outlook Much Worse, Not Better

During the debate over the health care law, it was often argued that the added federal cost of the coverage provisions would be more than offset by other tax hikes and spending cuts. Indeed, it was suggested that the new law would actually reduce the long-term budget deficit.

But this perspective rests critically on how one accounts for the Medicare taxes and cuts that were enacted in the law, and specifically the taxes and cuts that were assigned to the Medicare Hospital Insurance (HI) trust fund.

The Medicare HI trust fund, like Social Security, has generally been funded with dedicated taxes. Consequently, when the trust fund is projected to run short of funds, the only remedy is to increase revenue with tax hikes or slow spending from the trust fund with cuts.

Prior to enactment of the health care law, the HI trust fund was in exactly this situation (and continues to be to this day). Thus, some changes were needed to ensure the trust fund could continue paying full benefits beyond the moment when the trust fund

was projected to be depleted of reserves.

If those changes — new taxes dedicated to Medicare HI and Medicare HI spending cuts — had been enacted as standalone provisions, there's no question that the long-term budget outlook would have improved by the exact amount of the combined Medicare tax hike and spending cut.

But that's not what happened. Because, unlike Social Security, changes to Medicare HI not only shore up the trust fund, they also count under what is called the "paygo" scorecard for budget scorekeeping purposes. Consequently, in 2010, when the health law cut Medicare spending by about $450 billion, and raised substantial new revenue for the program too, *those funds were spent twice*: once to pay for Medicare benefits that were in jeopardy due to the depleted trust fund, and again to pay for the large entitlement spending increase contained in the health care law. As CBO Director Douglas Elmendorf put it, "The key point is that the savings to the HI trust fund under the PPACA would be received by the government only once, so they cannot be set aside to pay for future Medicare spending and, at the same time, pay for current spending on other parts of the legislation or on other programs."[1]

Some argue that while this may be true, it has been the longstanding practice of Congress to count Medicare HI changes in this manner. That is of course correct. But no previous legislation has come close to the 2010 health law in terms of the fiscal

[1] "Effects of the Patient Protection And Affordable Care Act On the Federal Budget And The Balance In The Hospital Insurance Trust Fund," Director's Blog, Congressional Budget Office, December 23, 2009 (http://www.cbo.gov/publication/25017).

consequences of this double-count. In a forthcoming paper from the Mercatus Center, the public trustee for the Medicare program, Charles Blahous, estimates that due in large part to this double-count, the health care law will add at least $340 billion cumulatively to federal deficits over the period 2012 to 2021.[2]

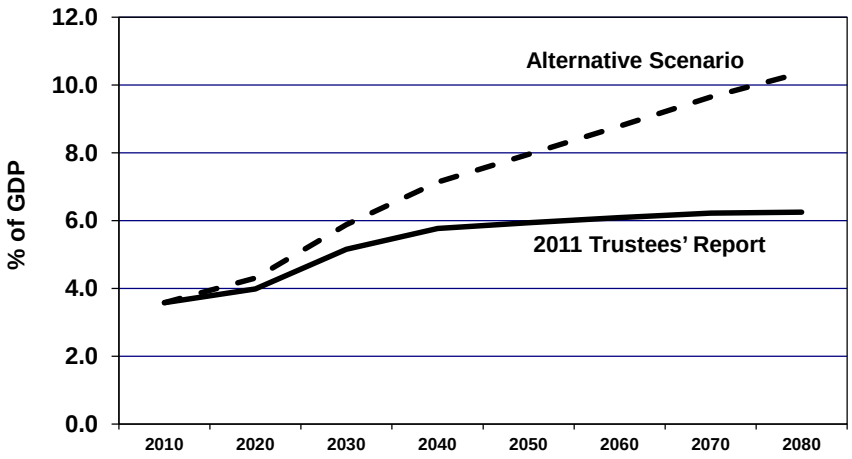
Over the long run, the added cost to the federal budget is even more staggering. In the 2009 Medicare Trustees' Report, the Medicare Trustees estimated the Medicare HI trust fund had an unfunded liability of $13.4 trillion over the seventy-five year projection period (in net present-value terms).[3] In the 2011 report, that unfunded liability was estimated at $3.0 trillion.[4] Thus, the double-counting of Medicare HI spending cuts and taxes has paid for both about $10 trillion in Medicare benefits over the next seventy-five years, *and* an equivalent amount of other entitlement spending in the health law.

Of course, this analysis of the double-count assumes that the Medicare cuts will be sustained at all over the coming years, which is very much in doubt because the cuts in the Medicare program contained in the health law are mainly blunt, across-the-board payment rate reductions that hit every provider of service the same regardless of the quality of care. According to the Office of the Actuary at the Centers for Medicare and Medicaid Services, the deepest of these cuts — the annual "productivity factor" adjustment — will push the total revenue for about 15 percent of all institutions,

[2] "The Fiscal Consequences of the Affordable Care Act," Charles Blahous, Mercatus Center (forthcoming).
[3] "2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," May 2009. p. 69.
[4] "2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," May 2011, p. 87.

including hospitals, that are providing services to Medicare patients below their total costs by the end of the decade, and thus force many them out of the Medicare program. By 2030, the percentage of "underwater" providers would reach 25 percent.[5] The actuaries have made it very clear that having such a large number of facilities with negative total margins would seriously jeopardize access to care for seniors, which is why they do not believe these Medicare cuts are viable over the long run.

Chart 2:
Long-Term Medicare Spending Projections: Two Scenarios



Source: "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," John D. Shatto and M. Kent Clemens, Office of the Actuary, Centers for Medicare and Medicaid Services, May 13, 2011 (http://www.cms.gov/ActuarialStudies/Downloads/2011TRAlternativeScenario.pdf).

For the past two years, the actuaries have issued an alternative analysis of Medicare's future spending path to give the public a more realistic assessment of the

[5] "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," John D. Shatto and M. Kent Clemens, Office of the Actuary, Centers for Medicare and Medicaid Services, May 13, 2011, p. 8 (http://www.cms.gov/ActuarialStudies/Downloads/2011TRAlternativeScenario.pdf).

program's future. As indicated in Chart 2, this alternative scenario shows Medicare spending rising from 4 to 10 percent of GDP over the coming decades instead of leveling off at about 6 percent of GDP in the official Trustees' projections. It's clear from this alternative scenario that the health law has not solved our health cost or entitlement problem.

Putting Health Spending on a Sustainable Path

The key question health reformers must answer is this: what *process* is most likely to succeed in bringing about continual and rapid improvement in the productivity and quality of patient care? Because the only way to slow the pace of rising costs without compromising the quality of American medicine is by making the health sector ever more productive. More health bang for the buck, if you will.

Providing an answer to this question requires properly diagnosing the problem. Why are health care costs rising so rapidly, including for the federal government? The prevailing view has been that the federal government's health programs experience rapidly rising costs because they are victims of the runaway cost train that is pulling the entire system down the tracks at too fast a rate. According to this way of thinking, the only way to slow the government's costs is to slow the whole train.

But this thinking misses a crucial point. Yes, one aspect of cost escalation is an exogenous factor. Rising wealth and medical discovery are fueling the demand for more

and better treatments. That should not be resisted in any event. But there is widespread agreement that costs are also high and rising because of waste and inefficiency—and here the problem is not some force outside of government's control but *existing* governmental policy.

At present, the vast majority of Americans get their health insurance through one of three sources: *Medicare*, for the elderly and disabled; *Medicaid*, for low-income households; and *employers* for the working-age population and their families. In each of these instances, the federal Treasury is underwriting rapid cost escalation because, as premiums rise, so does the federal subsidy.

Medicare's role is especially important in this regard. It is often said that American health care is characterized by extreme fragmentation and lack of coordination, much duplication and waste, an overemphasis on procedure-based medicine, and a lack of accountability for the all-too-frequent cases of low-quality care. That's all true. But why is it this way? The main reason is how Medicare is run today, and most especially the traditional fee-for-service (FFS) program.

Medicare is the largest purchaser of health services in most markets today. Four out of five enrollees are in the traditional FFS. With FFS, Medicare pays a pre-set rate to any licensed provider for any service rendered on behalf of a program enrollee, with essentially no questions asked. Nearly all Medicare beneficiaries also have supplemental insurance, from their former employers or purchased in the Medigap market. With this

additional coverage, they generally pay no charges at the point of service because the combined insurance pays 100 percent of the cost. This kind of first-dollar coverage provides a powerful incentive for additional use of services. Whole segments of the U.S. medical industry have been built around the incentives embedded in these arrangements. Moreover, all of the various providers of services have their own Medicare fee schedule, and can bill the program separately from all the others when they render services to Medicare patients.

Congress and the program's administrators have, without interruption, tried to hold down Medicare's costs by paying less for each service provided, and that's true also of the Medicare cuts in the health law. Those providing services to Medicare patients have responded by providing more services, and more intensive treatment, over time for the same conditions that patients present to them.

Some believe these problems can be fixed through federal efforts to "engineer" more cost-effective health care delivery. That's the theory behind Accountable Care Organizations, other Medicare pilot projects, the comparative effectiveness research funding, and the new $10 billion Center for Medicare and Medicaid Innovation.

But Medicare's administrators have been trying for many years to change the dynamic in the traditional fee-for-service program and have failed. Recently, CBO issued

a detailed report documenting the failure of scores of demonstration efforts to deliver better care at lower cost.[6]

The basic problem is that the only way to build a high-quality, low-cost network of care is to exclude those from the network who are low-value and high-cost. And that's something Medicare has never been able to do because that involves picking winners and losers. It's far easier, and more tempting, to simply impose across-the-board payment reductions for all providers of services, without picking among physicians and hospitals. And so such arbitrary cost-cutting has become the default mechanism for hitting budget targets of various kinds over the years.

Premium Support and Defined Contribution Health Care

The alternative to centralized cost-control efforts is a functioning marketplace with cost-conscious consumers. In 2003, Congress built such a marketplace, for the new prescription-drug benefit in Medicare. Two features of the program's design were important to its success. First, there was no incumbent government-run option to distort the marketplace with price controls and cost shifting. All private plans were on a level playing field. They competed with each other based on their ability to get discounts from manufacturers for an array of prescription offerings that are in demand among beneficiaries and their physicians.

[6] "Lessons from Medicare's Demonstration Programs on Disease Management, Care Coordination, and Value-Based Payment," Congressional Budget Office, Issue Brief, January 2012.

Second, the government's contribution to the cost of drug coverage is fixed and is the same regardless of the specific plan a beneficiary selects. The contribution is calculated based on the enrollment-weighted average of bids by participating plans in a market area. Beneficiaries selecting more expensive plans than the average bid must pay the additional premium out of their own pockets. Those selecting less expensive plans pay a lower premium. With the incentives aligned properly, participating plans know in advance that the only way to win market share is by offering an attractive product at a competitive price because it is the beneficiaries to whom they must ultimately appeal.

This competitive structure, with a defined contribution fixed independently of the plan chosen by the beneficiary, has worked to keep cost growth much below other parts of Medicare and below expectations. At the time of enactment, there were many pronouncements that using competition, private plans, and a defined government contribution would never work because insurers would not participate, beneficiaries would be incapable of making choices, and private insurers would not be able to negotiate deeper discounts than the government could impose by fiat. All of those assumptions were proven wrong.

What actually happened is that robust competition took place, scores of insurers entered the program with aggressive cost cutting and low premiums, and costs were driven down. Yesterday, at a hearing before the House Budget Committee, the chief actuary for Medicare, Richard Foster, testified that in every year of the drug benefit's

operation, seniors have migrated from high-cost, low-efficiency plans to low-cost, high-efficiency plans.

The result has been a strong record of success. In 2012, the average beneficiary premium is just $30 per month for seniors — up just $4 per month since 2006.[7] Overall, federal spending has come in roughly 40 percent below expectations.

Similar changes — what might be called a defined contribution approach to reform — must be implemented in the non-drug portion of Medicare, as well as in Medicaid (excluding the disabled and elderly) and employer-provided health care.

In Medicare, that would mean using a competitive bidding system — including bids from the traditional FFS program — to determine the government's contribution in a region. Beneficiaries could choose to enroll in any qualified plan, including FFS. In some regions, FFS might be less expensive than the competing private plans. But in some places, it almost certainly would not be, and beneficiary premiums would reflect the cost difference. This kind of reform could be implemented on a prospective basis so that those already on the program or nearly so would remain in the program as currently structured.

Moving toward a defined-contribution approach to reform would allow for much greater federal budgetary control, which is of course a primary objective and tremendously important for the nation's economy and long-term prosperity. But this isn't

[7] "Medicare Prescription Drug Premiums Will Not Increase, More Seniors Receiving Free Preventive Care, Discounts in the Donut Hole," Department of Health and Human Services, Press Release, August 4, 2011 (http://www.hhs.gov/news/press/2011pres/08/20110804a.html).

just a fiscal reform. It's a crucial step toward better health care too because it would put consumers and patients in the driver's seat, not the government. With consumers making choices about the kind of coverage they receive as well as the type of "delivery system" through which they get care, the health system would orient itself to delivering the kind of care patients want and expect.

Critics might claim that this improved fiscal outlook from defined contribution health care would come at the expense of the beneficiaries, who would bear the entire risk of costs continuing to rise faster than the government's newly fixed contribution. But that would only be the case if building a functioning marketplace had no discernible impact on the productivity of the health sector. It is far more likely that converting millions of passive insurance enrollees into cost-conscious consumers will have a transformative effect on health care delivery, and for the better. There would be tremendous competitive pressure on those delivering services to do more with less, and find better ways of giving patients what they truly need. Any health sector player that did not step up and improve its productivity would risk losing substantial market share.

At yesterday's House Budget Committee hearing, Mr. Foster was asked very directly by Chairman Paul Ryan if competitive bidding as part of a premium support model could help alleviate cost pressures in the rest of Medicare. His very direct answer was, yes, it could, and he based this response on the evidence he sees in the drug benefit, the other parts of Medicare, and modeling work his office has done over many years.

This committee should be commended for concerning itself with how to put health spending on a sustainable path. That is a crucial issue for the country. I believe the answer lies in moving away from a failed model of micromanaged payment systems and toward a decentralized system in which consumers themselves make the resource allocation decisions. That approach has the potential to keep costs under control even as it makes the system more responsive to patients' needs.