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HEALTH REFORM ESSENTIAL FOR REDUCING DEFICIT AND SLOWING HEALTH CARE COSTS

By Paul N. Van de Water

Because rising health care costs represent the single largest cause of the federal government's long-term budget problems, fundamental health reform must be part of any budget solution.[1] President Obama observed at a recent town hall meeting: "If you are serious about reducing our deficit and debt you cannot accomplish it without reforming our health care system, because that's what's gobbling up more federal dollars than anything else."[2]

It is a signal accomplishment that the Senate and House health reform bills would extend health coverage to two-thirds of the uninsured without adding to the federal deficit. According to the Congressional Budget Office (CBO), the bills would *reduce* deficits both over the decade from 2010 through 2019 (the Senate bill by $132 billion, the House bill by $138 billion) and after that.

The Senate bill, which is likely to serve as the basis for any final legislation, would reduce federal budget deficits over the decade from 2020 through 2029 by one-quarter to one-half percent of gross domestic product (GDP), according to CBO. That would amount to a cumulative reduction of some $650 billion to $1.3 trillion in deficits compared to those projected under current law.

The Senate bill would also substantially slow the rate of growth of spending for Medicare, which is the largest component of federal health spending. CBO projects that Medicare spending growth under the legislation would drop to about 6 percent a year during the next two decades — well below the 8 percent growth rate of the past two decades. Adjusting for inflation, the growth of Medicare spending per beneficiary would be halved — from 4 percent a year over the past two decades to 2 percent.[3] (The CBO estimate assumes that Congress will not act to forestall the reductions scheduled in physician payment rates in coming years. That, of course, is unlikely.

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[1] Kathy Ruffing, Kris Cox, and James Horney, *The Right Target: Stabilize the Federal Debt*, Center on Budget and Policy Priorities, January 12, 2010.

[2] *Remarks by the President and the Vice President at Town Hall Meeting in Tampa, Florida*, Office of the White House Press Secretary, January 28, 2010.

[3] Douglas W. Elmendorf, Director, Congressional Budget Office, Letter to the Honorable Harry Reid, December 20, 2009.

Nevertheless, if CBO took into account the expected enactment of legislation to avert the scheduled reductions in physician payments, it is likely that it still would estimate annual growth in Medicare spending per beneficiary to be significantly lower than it was in the past or would be in the future in the absence of the bill. That is because the Medicare savings in the bill are significantly larger than the cost of cancelling the scheduled reductions in the Medicare physician payment rates.)

The Senate bill includes an extensive array of provisions that hold considerable promise for slowing the growth in health care costs over the long haul. Many of these provisions are in the House bill, as well.

- In Medicare, the biggest savings stem from reducing or eliminating overpayments to private insurance companies that participate in Medicare Advantage, reducing annual payment updates for hospitals and other providers, and lowering prescription drug costs.

- The Senate bill would create an Independent Payment Advisory Board to develop and submit proposals to slow the growth of Medicare and private health care spending and improve the quality of care. The board's Medicare recommendations would take effect *automatically* unless Congress modified or overturned them. (If the board recommended changes that the President supported, those changes would go into effect unless both houses of Congress could muster a two-thirds vote to override a presidential veto and block them.) The Senate bill would also impose an excise tax on high-cost health insurance plans that would discourage excessive health care utilization.

- For health care as a whole, the bills include measures creating a health insurance exchange to promote competition among insurance plans, reducing the amount that insurers spend on administrative costs, expanding research on the comparative effectiveness of different medical procedures, investing in preventive care, penalizing hospitals with excessive readmission rates, and establishing pilot projects in Medicare for bundling payments for inpatient and post-acute care. These reforms are likely to complement and reinforce each other and to be much more effective in combination than separately.

- The bills would initiate a number of demonstration projects and establish a center for innovation to test and evaluate ways of improving quality and reducing the cost of health care. They would also give the Secretary of HHS additional authority to expand or implement successful cost containment strategies through administrative action — *without having to obtain approval from Congress in the face of opposition from providers, suppliers, and other interests.*

The Senate bill goes further in some aspects of cost control; the House bill goes further in others. The House bill would completely phase out (rather than scale back) overpayments to Medicare Advantage plans. It would also require drug manufacturers to pay greater rebates for drugs provided to low-income beneficiaries who are enrolled in both Medicare and Medicaid. Thus, the cost containment the Senate bill achieves could be strengthened by adding some of these House measures in an accompanying reconciliation bill.

Health care experts agree that slowing the growth of health care costs will require an ongoing process of testing, experimentation, and rapid implementation of what is found to work. Enactment of health reform would begin that process and, based on the CBO estimates, would represent the most significant deficit-reduction legislation in a number of years. Moreover, history suggests that if

the health reform legislation fails, the cost containment measures in it are likely to die as well, at least for a number of years.

For example, many of the cost containment provisions in the health reform bills reflect the recommendations of the Medicare Payment Advisory Commission (MedPAC), Congress' expert, nonpartisan advisory body on Medicare payment policy, on how to modify provider payment rates and encourage efficiency while assuring that payments are adequate so beneficiaries continue to have access to providers. In recent years, Congress has consistently ignored or failed to act on a number of important MedPAC recommendations. The current health reform bills represent a sharp break from that unfortunate tradition — they would enact many of the MedPAC recommendations into law despite the opposition of powerful interest groups. If health reform fails, Congress is unlikely to be able to pass these cost containment measures on their own.

Similarly, in the absence of health reform legislation, the proposed pilot and demonstration projects will face derailment or delay. The Senate bill would institute many such efforts, including a national pilot program for bundling payments, a demonstration program for chronically ill beneficiaries to receive home-based primary care, a childhood obesity demonstration project, a pilot study for additional pay-for-performance programs, and tests of innovative payment and service delivery models, including patient-centered medical homes and other approaches for coordinating care. If these projects are not enacted as part of health reform, valuable time — perhaps years — will be lost in the search to identify effective strategies to curb the growth of health care costs.

Economists across the political spectrum have stressed how health reform is essential for strengthening the nation's fiscal health and keeping health care costs under control. Last fall a group of 23 prominent economists — including two Nobel laureates and former members of both Republican and Democratic administrations (including Mark McClellan, head of Medicare and Medicaid for President George W. Bush, and Katherine Baicker, the member of Bush's Council of Economic Advisers who focused on health care) — sent a letter to President Obama about the priorities for health reform. The elements of the Senate bill, they wrote, "will reduce long-term deficits, improve the quality of care, and put the nation on a firm fiscal footing. It will help transform the health care system from delivering too much care, to a system that consistently delivers higher-quality, high-value care. The projected increase in federal budget deficits, as well as concerns about the value of the health care that Americans receive, make it particularly important to enact fiscally responsible and quality improving health reform now."[4]

Health Reform Bills Contain Wide Range of Cost-Control Measures

The health reform bill that the Senate passed (H.R. 3590) contains a wide range of measures to restructure the U.S. health system and slow the growth of health care costs, particularly Medicare costs. The House bill (H.R. 3962) contains many similar measures. The bills begin to move in most of the areas that health policy experts consider promising avenues for reducing the growth of health care spending and where specific steps can be identified. "Pretty much every proposed innovation

[4] "Economists' Letter to Obama on Health Care Reform," *New York Times, Economix Blog*, November 17, 2009. Those signing the letter also included Alan Blinder, vice chair of the Federal Reserve Board under President Clinton; Robert Reischauer and Alice Rivlin, former directors of the Congressional Budget Office; and Laura D'Andrea Tyson, chair of the Council of Economic Advisers under President Clinton.

Experts Affirm That Health Reform Bills Include Important Cost-Control Measures

"The bills contain no shortage of ideas for reforming the delivery system, enhancing the quality of care, and slowing spending. Pretty much every proposed innovation found in the health policy literature these days is encapsulated in these measures."

— John Iglehart, founding editor, *Health Affairs*
New England Journal of Medicine, November 11, 2009

The Senate bill "will reduce long-term deficits, improve the quality of care, and put the nation on a firm fiscal footing. It will help transform the health care system from delivering too much care, to a system that consistently delivers higher-quality, high-value care."

— Henry Aaron, Brookings Institution; Katherine Baicker, Harvard University;
and 21 other prominent health policy experts
Letter to President Obama, November 17, 2009

"Many, if not most, of the credible ideas that health policy analysts or economists have dreamed up over the past two decades for bending the cost growth curve or improving the quality of American health care are in the bills."

— Timothy S. Jost, professor of health law, Washington and Lee University
Health Affairs blog, December 21, 2009

found in the health policy literature these days is encapsulated in these measures," John Iglehart, founding editor of *Health Affairs,* recently wrote in the *New England Journal of Medicine.* (See the box on this page.)

Efficiencies in Medicare and Medicaid

The bills include a number of provisions that would make Medicare more efficient, providing significant savings that would help pay for health reform.[5] As noted above, many of these cost containment provisions are in line with recommendations of the nonpartisan Medicare Payment Advisory Commission — recommendations that Congress has heretofore ignored and is unlikely to adopt in the absence of health reform. In dollar terms, the bulk of the bills' reductions projected in Medicare expenditures come in three areas:

- *Reducing or eliminating Medicare Advantage overpayments.* MedPAC estimates that in 2010, Medicare will pay private insurers that participate in Medicare Advantage *13 percent more* per beneficiary, on average, than it would cost to cover these beneficiaries in traditional Medicare. The Senate bill would scale back these overpayments, saving $120 billion over ten years. The House bill would phase them out altogether over three years, as MedPAC has recommended, and along with other Medicare Advantage provisions, would save $170 billion. (All dollar estimates cited here are CBO estimates.)

- *Reducing the annual updates in Medicare fee-for-service payment rates.* Medicare payment rates for covered services are updated annually according to formulas specified in law. The Senate bill

[5] Edwin Park and others, *House Health Reform Bill Expands Coverage and Lowers Health Cost Growth, While Reducing Deficits,* Center on Budget and Policy Priorities, November 6, 2009; Chuck Marr and others, *Senate Health Reform Bill Is Fiscally Responsible,* Center on Budget and Policy Priorities, November 19, 2009.

— and the House bill as well — would reduce annual payment updates to hospitals, skilled nursing facilities, hospices, ambulatory surgical centers, and certain other health care providers to account for improvements in economy-wide productivity. The bills would also reduce payments to home health agencies, skilled nursing facilities, and inpatient rehabilitation facilities, as MedPAC has recommended. The House bill would save $228 billion over ten years from such changes; the Senate bill would save $186 billion.

- *Reducing prescription drug costs*. The Senate and House bills would increase the rebates that drug companies pay for drugs that Medicaid covers, saving $38 billion and $25 billion, respectively. In addition, the House bill would require drug manufacturers to provide, at a minimum, the same rebates for drugs provided to dual eligibles (low-income Medicare beneficiaries who are also enrolled in Medicaid) under Medicare's prescription drug benefit that Medicaid formerly required for those drugs. Some of the resulting savings would be used to fill the so-called "doughnut hole" in the Medicare drug benefit, but this provision would still produce net savings of $42 billion over ten years.

Payment Advisory Board

The Senate bill would establish an Independent Payment Advisory Board to develop and submit proposals to slow the growth of Medicare and private health care spending and improve the quality of care. The President would nominate the board's 15 members, who would require Senate confirmation, for staggered six-year terms.

If the projected growth in Medicare costs per beneficiary in 2015 and thereafter exceeded a specified target level — which it almost certainly would do in many years — the board would be required to produce a proposal to *eliminate the difference*.[6] The board could not propose increases in Medicare premiums or cost-sharing or cuts in Medicare benefits or eligibility criteria; it would focus on proposals for savings in the *payment and delivery* of health care services. The board's recommendations would go into effect *automatically* unless both houses of Congress passed, and the President signed, legislation to modify or overturn them. If the board recommended changes that the President supported, the President could veto any congressional attempt to block them, and a two-thirds vote of both the House and Senate would be required to override the veto.

Systemic Reforms in Health Care Payment and Delivery

Both bills take numerous important steps to begin restructuring the health care payment and delivery systems to move away from paying providers for more visits or procedures and toward rewarding effective, high-value health care. Most of these provisions are not estimated by CBO to save much money in the next ten years because their effects — while promising — are not proven at this point. But they constitute important initial efforts to slow the growth of health care costs, and they might well lead to larger savings than the official cost estimates suggest. Moreover, the proposed reforms are likely to reinforce each other and have a combined effect that exceeds the sum of the individual parts. If given the appropriate financial incentives, providers will seek ways to strengthen the delivery of primary care, use the results of comparative effectiveness research to

[6] The required reductions could not exceed 0.5 percent of Medicare spending in 2015, 1.0 percent in 2016, 1.25 percent in 2017, and 1.5 percent in 2018 and thereafter. These limitations are prudent — larger reductions would run the risk of being too severe, adversely affecting beneficiaries' access to providers, and might therefore be overturned by Congress.

select high-value treatments, employ electronic health records (for which the February 2009 recovery act provides substantial funding) to manage and coordinate care, and make other needed improvements in the health care delivery system.

Many of the proposals involve Medicare, which has been a leader in developing and testing effective payment reforms that private insurers later adopt widely. As the largest U.S. purchaser and regulator of health care, Medicare exerts a major influence on the rest of the health care system; its reimbursement and coverage policies have served as models for private insurers and other public programs. For example, many private insurers follow Medicare's lead in approving coverage of new medical technologies. Over the years, the private sector has also typically followed Medicare's lead in adopting new payment mechanisms — including the prospective payment system for hospitals and fee schedules for physicians.[7]

Provisions of the Senate bill — or both bills — that could start to "bend the cost curve" include:

- *Creating a health insurance exchange.* The bills would create a health insurance exchange that would offer eligible individuals and employers a choice of insurance options that are affordable and comprehensive. A well-structured exchange should reduce administrative costs and promote competition among insurers based on the cost and the quality of their products, not their ability to maximize profits by attracting healthy, less costly enrollees and avoiding sicker, more costly ones. Economist Henry Aaron has termed the exchange a potentially "revolutionary innovation" that could become "capable of effecting real systemic change."[8]

- *Establishing an excise tax on high-cost insurance plans.* This provision of the Senate bill would discourage insurers from offering, and firms from purchasing, very generous health insurance coverage that can encourage excess health care utilization. According to CBO, limiting the open-ended tax exclusion for employer-sponsored health insurance is one of "two powerful policy levers" the federal government has available to encourage changes in medical practice and slow health care costs.[9] The recent agreement that Administration officials and labor leaders negotiated fixes the principal problem with the Senate provision — that it could tax some plans that are *not* overly generous but that have a high cost because the plans' enrollees are disproportionately older and sicker. That agreement also increases the tax thresholds and adds transitional provisions for health plans covered under collective bargaining agreements. With these changes, the excise tax would take longer to have a significant effect on health care costs than would have been the case under the Senate-passed bill — but it would still make an important contribution to containing the growth of health care costs.[10]

- *Reducing administrative costs.* High administrative costs are one reason that health care is more costly in the United States than in other western industrialized nations, and both bills would

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[7] Rick Mayes and Robert A. Berenson, *Prospective Payment and the Shaping of U.S. Health Care*, Johns Hopkins University Press, 2006.

[8] Henry J. Aaron, "Remarks for the 20th Anniversary of the Department of Health Care Policy, Harvard Medical School," April 29, 2008.

[9] Douglas W. Elmendorf, Letter to the Honorable Kent Conrad, June 16, 2009.

[10] Paul N. Van de Water, *Changes to Excise Tax on High-Cost Health Plans Address Criticisms, Retain Long-Term Benefits*, Center on Budget and Policy Priorities, January 26, 2010.

reduce the amount that insurers spend on administrative overhead rather than health care. The bills take steps toward standardizing transactions between insurers and providers, including transactions related to enrollment, eligibility determination, prior authorization, and claims.

- *Establishing a center for innovation*. The bills would establish a center for innovation within the Centers for Medicare & Medicaid Services to test and evaluate payment structures and methods to foster patient-centered care, improve quality, and reduce the cost of care in Medicare and Medicaid. The HHS Secretary would also be authorized to expand the scope and duration of approaches being tested, including implementation on a nationwide basis without waiting for congressional action, if they are found to reduce health care expenditures without reducing the quality of care.

- *Researching comparative effectiveness.* The bills would establish an independent entity with a dedicated source of funding to conduct and synthesize research on the comparative effectiveness of different medical services, treatments, and items. According to CBO, "Such research holds the potential to reduce health care costs over the long term — possibly by substantial amounts if it is done rigorously and if its results are ultimately tied to changes in financial incentives for providers and consumers."[11]

- *Promoting prevention and wellness*. Both bills include provisions aimed at preventing disease and encouraging wellness and healthy behaviors, including coverage of additional preventive services in Medicare, Medicaid, and private health insurance.

- *Licensing follow-on biologics.* Both bills would establish an abbreviated regulatory procedure for approving generic versions of biological drugs (drugs derived from living organisms). Public and private purchasers of drugs would save money from the availability of these new, lower-priced versions.

- *Strengthening primary care.* Improving primary care and care coordination is widely viewed as a promising way of increasing value and achieving savings in U.S. health spending.[12] Both bills would increase payments to primary care providers in Medicare and provide incentives to increase the number of nurses and doctors in primary care. They would also expand efforts to assess the feasibility of making Medicare payments to qualified patient-centered medical homes — a model in which each patient has an ongoing relationship with a primary care physician who leads a team that coordinates and takes responsibility for his or her care.

- *Establishing quality measures and priorities.* Both bills would direct the HHS Secretary to establish national priorities for improving the quality of health care services and health outcomes and to develop new patient-centered and population-based measures of quality. Such a foundation of information could provide essential guidance in moving toward a health care system that slows spending growth while improving value.[13]

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[11] Peter R. Orszag, "Comparative effectiveness options in health care," Congressional Budget Office Director's Blog, December 18, 2007.

[12] Cathy Schoen and others, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, The Commonwealth Fund, December 2007.

[13] Mark B. McClellan and others, *Bending the Curve: Effective Steps to Address Long-Term Health Care Spending Growth*, Engelberg Center for Health Care Reform at the Brookings Institution, September 2009.

- *Promoting high-value care.* Experts agree that slowing the growth of health costs requires moving toward a payment system that rewards providers based on the value of their care, not just the volume of their procedures. The Senate bill would create systems of value-based payments in Medicare for physicians, hospitals, skilled nursing facilities, and home health agencies.[14]

- *Enhancing program integrity.* The bills contain numerous provisions to improve program integrity and reduce fraudulent payments in both Medicare and Medicaid. These include strengthened legal requirements and authorities to prevent fraud and abuse and to facilitate its detection, enhanced penalties for violations, and increased funding for enforcement.

- *Reducing avoidable hospital readmissions.* MedPAC has found that nearly 18 percent of hospital admissions among Medicare beneficiaries in 2005 occurred within 30 days after the individual was discharged from the hospital. MedPAC also found that hospitals could have prevented some of these readmissions and saved money by providing better care during the initial stay or better follow-up care after discharge.[15] The bills would reduce Medicare payments to hospitals with high readmission rates to encourage them to do a better job of preventing avoidable readmissions.

- *Promoting accountable care organizations.* The bills would create new Medicare payment models to reward accountable care organizations (ACOs) — physician-led organizations that take responsibility for the cost and quality of the care they deliver. Many analysts believe ACOs can significantly reduce costs.[16] The Senate bill would allow groups of providers who meet specified criteria to qualify as ACOs and thereby receive a share of any savings they achieve.

- *Examining payment bundling.* Both bills would establish pilot programs for bundling payments for Medicare services that hospitals and post-acute care providers (such as nursing homes and rehabilitation facilities) provide during an episode of care. They would require the Secretary to develop a plan to implement bundled payments if the pilot programs prove successful. If providers received a single payment for hospital and post-acute services rather than a separate reimbursement for each service, they would have a greater incentive to coordinate and deliver more cost-effective care. Bundling payments, encouraging accountable care organizations, and reducing avoidable hospital readmissions would also help move towards a payment system that promotes high-value, high-quality care**.**

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[14] The House bill would direct the Institute of Medicine, the health arm of the National Academy of Sciences, to study the extent and causes of geographic variation in health spending and how to promote high-value care. It would also instruct the HHS Secretary to develop a plan for modifying Medicare payments to implement these recommendations, which would go into effect unless Congress disapproves.

[15] Marr and others.

[16] Kelly Devers and Robert Berenson, *Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?*, Urban Institute, October 2009.

Curbing Health Costs Will Be a Continuing Process

Some have criticized the bills' reliance on pilot projects, pointing out that a number of previous pilot projects have not led to changes in Medicare. In most of those cases, however, the Administration and Congress did not expand the experiment because it failed to save money or improve care.[17]

In some cases, political pressure from doctors, hospitals, or other providers caused Congress to block implementation, but the health reform bills attempt to avoid this roadblock by giving the Secretary authority to implement successful pilots without congressional approval. Congress could consider further strengthening these provisions by requiring prompt implementation of approaches that prove effective.

Some who claim the bills fall short on cost containment fail to acknowledge that many highly touted proposals for slowing the growth of health care costs are not ready for immediate large-scale implementation and will require time and testing. In a widely cited article in *The New Yorker,* surgeon and author Atul Gawande explained the situation this way: "Almost half of [the Senate bill] is devoted to programs that would test various ways to curb costs and increase quality. . . . [It] contains a test of almost every approach that leading health care experts have suggested. . . . None of this is as satisfying as a master plan. But there can't be a master plan. That's a crucial lesson. . . . But if we're willing to accept an arduous, messy, and continuous process we can come to grips with a problem even of this immensity."[18]

[17] Christopher Weaver and Kate Steadman, "Medicare Experiments to Curb Costs Seldom Implemented on a Broad Scale," *Kaiser Health News,* November 3, 2009.

[18] Atul Gawande, "Testing, Testing," *The New Yorker,* December 14, 2009, pp. 34-41.