Statement to the Senate Finance Committee Roundtable

Financing Health Care Reform

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The views expressed in this testimony are those of the author alone and do not necessarily represent those of the American Enterprise Institute.

Mr. Chairman and members of the Committee, thank you for inviting me to participate in this roundtable discussion on financing health care reform. I am Joseph R. Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute (AEI), a non-profit, non-partisan public policy research organization based in Washington, D.C. I am also a member of the panel of health advisers for the Congressional Budget Office (CBO). My comments today are my own and do not necessarily reflect the views of AEI, CBO, or other organizations with which I am affiliated.

There is little question about the need to reform America's health care system. The country spent $2.2 trillion for health care last year, but a significant portion of that spending is likely to have provided little if any value to the well-being of patients.[1] Health insurance costs have been rising more rapidly than workers' wages, putting insurance increasingly out of reach for millions of people. Although much public attention has focused on expanding coverage for the uninsured, that goal is tied to our efforts to reform the delivery system and to establish a responsible financing system that is sustainable into the future.

There are two basic ways to finance a reformed health system: raise revenue or reduce health spending. We will undoubtedly do both. What matters is whether we take advantage of this moment in history to promote greater efficiency, greater consumer involvement, and smarter health purchasing—to achieve better health outcomes while living within a realistic budget constraint.

Current Spending Trends are Unsustainable

If current trends continue, national health spending will nearly double over the next decade—rising from $2.2 trillion, or 16.2 percent of gross domestic product (GDP), in 2007 to over $4.3 trillion, or 20.3 percent of GDP, in 2018.[2] Health spending is projected to grow at an average rate of 6.2 percent a year, about 50 percent faster than growth in the economy. By 2035, total health spending could exceed 30 percent of GDP.[3]

This rapid growth in overall health spending is mirrored in the federal budget. In 2007, federal outlays for Medicare and Medicaid totaled $425 billion, or about 15 percent of the budget.[4] By 2035, those programs could grow to more than a third of total federal spending.[5] Because spending is rising much more quickly than program revenue, the Medicare trust fund for Part A is likely to run short of money as soon as 2015.[6]

These spending figures are cause for alarm. The rapid growth of health spending has placed increasing pressure on everyone's budgets—consumers, employers, and all levels of government. Premiums for health insurance offered through employers have doubled since 1999 and outstripped growth in wages.[7] Rising federal health costs threaten to crowd out education, energy, transportation, and other policy priorities. According to the CBO, "the rate at which health care spending grows relative to the economy is the most important determinant of the country's long-term fiscal balance."[8]

Current health spending trends are fiscally unsustainable for the federal government, and they impose a rising burden on families that will ultimately prove unbearable.[9] Moreover, increasing costs make health insurance unaffordable to larger numbers of people. Policies that effectively rein in health spending can promote a more sustainable system and at the same time promote insurance coverage for many more individuals.

Increasing federal insurance subsidies or expanding eligibility for federal programs can make insurance more affordable and accessible to the uninsured. Policies intending to achieve universal coverage could add $1.8 trillion to the nation's health bill over the next decade.[10] But simply asking others to pay more is ultimately self-defeating unless we find ways to reduce health costs while preserving a high-value health system. As Chairman Baucus has written, "excess spending must be eliminated and dollars put to better use, not only to correct the imbalances of the current health system, but to offset the high costs of much-needed comprehensive reform."[11]

Financing Options

There are hundreds, perhaps thousands, of specific proposals that could help finance the health care system. The CBO has provided a useful guide for Congress containing 14 broad categories and 115 separate options, but this only scratches the surface.[12] Each of those options could be specified in legislative language in numerous ways, each of which potentially resulting in very different impacts on the federal budget, the health sector, and the economy.

At the risk of oversimplifying, I focus on several types of proposals (including some that were not explicitly considered by CBO) that have been advanced in various health reform discussions. The proposals discussed here illustrate the trade-offs and challenges facing Congress in designing a financing strategy for health reform.

Raise taxes. Although one of the major objectives of reform is to gain control over the high and rapidly rising cost of health care, accomplishing that goal will require considerable time and effort on the part of everyone. Consequently, most reform proposals include policies to increase federal revenue.

President Obama proposes to limit the rate at which itemized deductions reduce the tax liability of high-income individuals.[13] Rep. John Dingell (D-Mich.) has long proposed a value-added tax to finance universal coverage.[14] Such proposals do nothing to improve the value we receive from our health care dollar since they raise taxes on activities and income largely outside the health sector. Absent other reforms, raising taxes in this manner to pay for expanded health care coverage would reinforce the inefficiency of the current health system and would have a dampening effect on an already depressed economy.

Other tax proposals, discussed below, operate within the health sector. Such proposals, including limiting the current tax exclusion for health insurance, could promote efficiency while raising substantial revenue to support insurance expansions.

Impose mandates. A variety of mandates have been proposed as part of health care reform. Under "play or pay," firms would be required to provide health insurance coverage to their employees or pay a fine. Any fines that were collected could be used to defray the cost of expanding government health programs or subsidies for insurance. Firms choosing to begin offering coverage would use their own funds to accomplish the policy goal of expanded coverage.

The impact of an employer mandate on the federal budget would be negligible, even though employers might spend substantial new sums to provider health insurance to their employees. Although that spending would be treated as private, it is equivalent to a tax on the firm and a subsidy to the workers of the same amount. With a mandate, the IRS middleman is cut out and the cost of expanding coverage is shifted off-budget. This does not represent any savings to the economy even though the federal cost of the expansion is lower on the government's books than it would have been without a mandate.

An employer mandate does not generate free money. It can have damaging effects on the low-income workers it is meant to help. Employers who "play" would seek to recover the now-higher costs of labor by slowing wage increases, cutting other benefits, reducing new hires, and laying off less-productive workers.

An individual mandate to purchase insurance similarly requires individuals to purchase their own health coverage. Because such a mandate may be difficult to enforce (particularly among low-income families), many proposals include subsidies to make the purchase of insurance more feasible. More generous subsidies increase the effectiveness of the mandate in promoting coverage, but they also increase federal outlays.

Other government policies can also impose unfunded mandates that shift the cost of reaching a policy goal to the private sector without incurring a federal budgetary cost. For example, Medicare could require health care providers to institute quality improvement programs or increase reporting requirements without offering additional payment to providers who comply. For this reason, the federal budget can be a poor indicator of the economic impact of complex proposals. Congress should carefully weigh the broader effects of policy as well as the federal budget impact when seeking ways to "pay" for health reform.

Control prices. Medicare and Medicaid have long used price controls to limit the growth of program spending. While such measures can be effective in constraining costs in the near term, they also may have undesirable consequences for enrollees. Medicaid payment rates are substantially below those of other payers, and many health providers refuse to accept Medicaid patients. This leads patients to seek care in the hospital emergency department, which is often the most expensive and least effective way to manage routine health care needs.[15]

Medicare has also limited increases in its reimbursement rates to constrain spending, with mixed results.[16] Provider payments are generally established by formula, not by direct

negotiation with providers. As a result, some prices may be too high, and some too low. This distorts the allocation of resources in health care, and attempts to adjust the payment formulas to ameliorate those distortions are unlikely to succeed. As with Medicaid, the failure of Medicare pricing formulas to accurately reflect both the market demand for specific medical services and the cost of producing those services leads to the misallocation of health resources, less efficiency in delivering health care, and higher program spending.

Price controls can also have serious long-term consequences by discouraging the development of new treatment methods and other medical innovations. For example, proposals that would limit Medicare payments for new drugs to be no greater than the least costly alternative would constrain Medicare costs in the near term. However, such proposals would also discourage the research and development necessary to find and bring to market the next potentially life-saving drug. Price controls can slow medical progress, ultimately resulting in less effective treatments and poorer patient outcomes—real costs that do not show up on the government's ledger.

Other pricing approaches, such as competitive bidding, could promote more efficient resource allocation, minimizing the distortions caused by formula-based pricing. Such market-based pricing methods are discussed below.

Control utilization. Price increases account for perhaps a third of the growth in health spending from year to year. The rest is driven by increases in the use of services, including both newly-introduced medical innovations as well as long-established medical practices. Although most of those services provide real value to patient well-being, there is substantial variation in the use of health services across the U.S. with little detectable differences in mortality and other outcome indicators. If high-cost areas adopted the conservative practice styles of low-cost areas, Medicare spending could be reduced by as much as 29 percent according to one study.[17]

Medicare is prohibited by the Social Security Act from interfering with the practice of medicine, but coverage and payment policies necessary to define the scope of any insurance benefit have powerful influence on what care is available to beneficiaries. Comparative effectiveness research (CER) has been proposed as a way to identify the most clinically effective medical interventions, which could provide a basis for restricting coverage or limiting payments for less effective treatments and thus reduce wasteful variations in practice.

There is considerable debate over the proper government role in this work, with concerns that government control over the research could lead to rationing of care by Medicare and private insurance.[18] Although recent proposals avoid introducing cost comparisons into the research, it is difficult to imagine that *cost* effectiveness would not become part of the *comparative* effectiveness agenda. However, there are serious questions about the ability of CER to yield clear-cut, actionable guidance on best medical practices that would result in substantial savings.[19] Because patients with a specific illness are diverse and often have multiple conditions that complicate medical decisions, the results of CER are more

appropriately a guide to physicians and patients rather than a basis for the blanket exclusion of specific treatments.

Improve efficiency in the delivery of health care. A more efficient delivery system can save money and improve health outcomes. There are a host of proposals—including greater use of health information technology (HIT), comparative effectiveness research, disease management and other forms of coordinated care, and medical homes—that are intended to re-engineer health care delivery. Although such proposals seem to offer a painless solution to rising health costs, the health industry, insurers, and the government have invested billions of dollars over several decades in their attempts to move from concepts to functioning systems.

The CBO has analyzed the most prominent types of delivery reform proposals and found little evidence to suggest that such initiatives would soon yield substantial savings.[20] That does not necessarily imply that additional work on such proposals would be a poor investment, but it does suggest caution is needed in determining appropriate federal action.

Federal policy can provide incentives to promote further development and adoption of delivery system innovations. For example, the stimulus legislation offers a carrot and stick approach to promote HIT. Grants will be available to health care providers who adopt electronic health records, and Medicare reimbursements will be reduced for those who fail to meet requirements on acceptable use of such records. There is a risk, however, that excessive direction from Washington could have a deadening effect on local efforts by providers and health plans to find their own solutions to improve health care delivery.

Other re-engineering efforts more clearly require government leadership. Medical malpractice reform—which could include the creation of specialized health courts or other administrative mechanisms outside the current judicial system, new requirements to ensure timely action, and caps on awards—could reduce costs and lower malpractice premiums. More importantly, such reforms could reduce the practice of defensive medicine, which adds to the cost of care without providing real benefit.

In addition to these approaches to change the delivery system from the provider side, patients can also be given incentives to improve their own health behaviors. Wider access to preventive health services, such as screening for diseases and medications to control chronic diseases, is a component of many reform plans. However, hundreds of studies have found that medical prevention usually adds to health spending.[21] More basic preventive measures, such as changes in diet and exercise, may be more likely to have a pay-off in both better health and lower health spending.

Financial incentives might be useful in promoting healthy lifestyles. Congress increased the federal excise tax on cigarettes from 39 cents to $1 a pack to pay for the expansion of the Children's Health Insurance Program. Proposals have been advanced to impose an excise tax on sugar-sweetened beverages. These "sin taxes" raise the cost of consuming

products that might be bad for your health, which would reduce their consumption—generally to a limited extent. However, their principal purpose is to generate revenue, with an incidence falling most heavily on low-income people. Any savings from improvements in personal behavior generally accrue over long periods of time, well outside the budget window.

Promote competition and informed choice. The system re-engineering approach just discussed has the potential for eventually improving health system efficiency and cutting cost through changes on the supply side of the market. We must also enlist the help of consumers and the demand side of the market if we expect to maintain or improve health care value while permanently reducing the growth of health spending. Cost cutting is not likely to succeed unless the public understands its necessity and agrees with the methods.

I will focus on three major policy options that can promote a more effective competition in the health marketplace that can improve efficiency and reduce spending. Those options are: limiting the tax exclusion for employer-sponsored insurance, using competitive bidding methods to establish payment rates for providers and health plans, and implementing full premium support in Medicare.

First, the tax exclusion. Reducing tax benefits for employer-sponsored health insurance is the largest potential source of money to finance health reform. About two-thirds of the working population and their dependents receive health insurance through an employer, who typically pays a substantial portion of the premium on behalf of the employee. Those premium contributions are excluded from the worker's taxable income, resulting in thousands of dollars of savings for the typical family. In 2007, the tax exclusion reduced federal tax revenue by $246 billion.

The tax exclusion is unfair, providing tax savings to people on the basis of their employment rather than on their need for financial help. Individuals purchasing their own health insurance outside of their employer do not receive the tax break. Moreover, because the amount of the exclusion is not limited, it encourages firms to offer generous health plans with high premiums and minimal cost-sharing. By minimizing the amount that enrollees must pay out of pocket, such plans promote the use of health services whose value to the patient might be well less than the cost of providing the care.

One way to phase in changes in the exclusion is to cap it at a high level (such as the 75th percentile of insurance premiums) and index it to general inflation rather than medical inflation. Another approach would replace the exclusion with a standard deduction. Under both approaches, individuals buying high-cost health insurance would be required to pay a tax on the amount over the cap or standard deduction. That would generate pressure from workers to their employers for less-expensive insurance options. The additional tax revenue collected in this way could be used to fund refundable tax credits or other subsidies to low-income persons for the purchase of insurance.

Second, competitive bidding. Medicare's formula-based pricing methods are imprecise, resulting in excessive reimbursement for some services and insufficient reimbursement

for others. That, in turn, distorts the allocation of resources in the health sector and is a major reason why primary care is in short supply in many parts of the country. Formulas can only guess at the correct structure of prices in a market, and they generally get it wrong.

The solution is competitive bidding, which essentially asks the market to reveal the lowest price Medicare could pay and be assured that beneficiaries would have sufficient access to care. Competitive bidding has been tested successfully for the payment of durable medical equipment (DME). The Centers for Medicare and Medicaid Services (CMS) announced in April that it was ready to proceed with competitive bidding for DME in ten metropolitan areas, but resistance from suppliers has put this project on hold. If political opposition could be overcome, competitive bidding methods could potentially provide substantial program savings.

However, the bidding process must be designed carefully to ensure that savings will be realized. The Medicare Advantage (MA) program has been criticized because bids are set against benchmarks that generally exceed the cost of providing services through the traditional Medicare fee-for-service program. Consequently, MA plans are paid an average of 14 percent more than the fee-for-service costs. Those extra payments guarantee that seniors have a choice of plans no matter where they live, and the additional money supports optional benefits for many enrollees. Nonetheless, from a narrow budgetary perspective, the structure of MA bidding has increased the cost of the program.

In sharp contrast, Medicare prescription drug plans also present bids to CMS but that process does not have an external benchmark. Part D spending has consistently dropped below the initial projections made by the CBO. This is strong evidence that competition, when carefully structured, can reduce program costs.

Third, premium support. As an entitlement, Medicare guarantees a level of health benefits that is not bound by spending limits imposed by other programs through the appropriations process. The entitlement is as much for providers as it is for beneficiaries, since it ensures payment for the wide range of services covered by the program. Moreover, most beneficiaries have supplemental coverage that pays their deductibles and copayments. That insulates patients from the cost of their care, removing a financial incentive to reduce the use of unnecessary services.

A premium support system would set a fixed government contribution for each beneficiary, adjusted for their income and health status.[22] The average contribution level would be determined by a bidding process among private plans participating in Medicare and the traditional fee-for-service program. For example, the government contribution might be set at 85 percent of the cost of the average bid (which is similar to the current level of subsidy in Medicare), or it could be adjusted upward or downward. Beneficiaries would be able to purchase more expensive plans, but the additional cost would be their own responsibility.

Such a system would provide a mechanism to restrain federal spending on Medicare, and it would stimulate greater price competition among health plans by making beneficiaries more cost-conscious. However, a poorly designed premium support program could expose beneficiaries to unacceptable financial burdens.

Premium support met strong resistance when it was advanced in a series of demonstration projects in the late 1990s, and it is not a politically popular idea today. Leading health reform advocates are often more focused on expanding access and coverage than on making the reformed system fiscally sustainable.

Nonetheless, the point remains that top-down cost containment measures—primarily through price controls on provider reimbursements—have not been especially successful in limiting the growth of Medicare outlays. If a reformed health system is to succeed, it will have to engage consumers to take more responsibility for their health spending decisions.

Conclusion

Congress would be well advised to take a hard look at the options available to finance a reformed health system. Contrary to what is often claimed, there is no "low-hanging fruit." Many options, including those that would re-engineer the delivery system, will require further investment of time and money before we can begin to see greater efficiency, improved quality, and lower cost. Much of that work must be done in local markets among providers and health plans that know best what the biggest challenges are in providing high-value health care. Top-down controls are likely to impede our evolution toward a more functional health system.

Realistic health reform recognizes the need to make compromises among competing goals and find a balance among conflicting demands. We can have a system that provides higher quality care and greater economic value, but we cannot continue to ignore the resource limits that constrain all human endeavors. We have an historical opportunity this year to take major steps to promote a high-value health system that we can, in fact, afford.

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[1] Micah Hartman et al., "National Health Spending In 2007: Slower Drug Spending Contributes To Lowest Rate Of Overall Growth Since 1998," *Health Affairs*, January/February 2009; 28(1): 246-261; CBO, *Geographic Variation in Health Care Spending* (Washington: CBO, February 2008) and references cited therein.

[2] Andrea Sisko et al., "Health Spending Projections Through 2018: Recession Effects Add Uncertainty To The Outlook," *Health Affairs*, March/April 2009; 28(2): w346-w357.

[3] CBO, *The Long-Term Outlook for Health Care Spending* (Washington: CBO, November 2007).

[4] CBO, *The Budget and Economic Outlook: An Update*, (Washington: CBO, September 2008).

[5] Author's calculation based on CBO, *The Long-Term Budget Outlook* (Washington: CBO, December 2007), Table 1-2 ("Alternative Fiscal Scenario").

[6] In 2008, the Medicare trustees projected that the Part A trust fund would have insufficient funds to cover expenses by 2019. Partly because of the severe recession, that date is likely to be moved up to 2015.

[7] Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits: 2008 Annual Survey* (Menlo Park: Kaiser Family Foundation, September 2008).
[8] CBO, *Key Issues in Analyzing Major Health Insurance Proposals* (Washington: CBO, December 2008), p. 20.
[9] Alice M. Rivlin and Joseph R. Antos (eds.), *Restoring Fiscal Sanity 2007: The Health Spending Challenge* (Washington: Brookings Institution, 2007).
[10] Author's calculation based on Jack Hadley, et al., "Covering The Uninsured In 2008: Current Costs, Sources Of Payment, And Incremental Costs," *Health Affairs*, September/October 2008; 27(5): w399-w415. Calculation assumes an average growth rate of 7 percent a year for the incremental health spending from extending coverage to everyone.
[11] "Finance Chairman Baucus Unveils Blueprint for Comprehensive Health Care Reform," press release, November 12, 2008.
[12] CBO, *Budget Options Volume I: Health Care* (Washington: CBO, December 2008).
[13] Office of Management and Budget, *A New Era of Responsibility: Renewing America's Promise* (Washington: U.S. Government Printing Office, February 2009).
[14] Meena Seshamani et al., *Financing the U.S. Health System: Issues and Options for Change* (Washington: Bipartisan Policy Center, June 2008).
[15] Peter J. Cunningham, "What Accounts For Differences In The Use Of Hospital Emergency Departments Across U.S. Communities?" *Health Affairs*, September/October 2006; 25(5): w324-w336.
[16] One study found that Medicare spending has grown less rapidly over long periods of time than private insurance spending; see Cristina Boccuti and Marilyn Moon, "Comparing Medicare And Private Insurers: Growth Rates In Spending Over Three Decades," *Health Affairs* March/April 2003; 22(2): 230-237. Other analysts argue that adjustments to reflect differences in covered benefits between Medicare and private coverage reverses that conclusion; see Joseph R. Antos, "Comparing Medicare and Private Health Insurance Spending," Heritage Foundation *WebMemo* no. 250, April 8, 2003; and Joint Economic Committee, *Health Insurance Spending Growth – How Does Medicare Compare?* June 10, 2003.
[17] John E. Wennberg et al., "Geography And The Debate Over Medicare Reform," *Health Affairs* Web Exclusive, February 13, 2002: w96-w114.
[18] For example, Sen. Jon Kyl (R-Ariz.) stated in the confirmation hearing for Secretary Sebelius that "the government can misuse comparative effectiveness research to deny coverage." See Taylor, Lynne. "Obama's Pick for Health Secretary in 'US NICE' Row". PharmaTimes: 23 April 2009. <http://www.pharmatimes.com/WorldNews/article.aspx?id=15733> Accessed 4 May 2009. For an analysis of the potential risks of CER, see Scott Gottlieb, "Promoting and Using Comparative Research: What Are the Promises and Pitfalls of a New Federal Effort?" *AEI Health Policy Outlook*, February 2, 2009. <http://www.aei.org/outlook/100010> accessed May 7, 2009.
[19] CBO, *Research on the Comparative Effectiveness of Medical Treatments: Issues and Options for an Expanded Federal Role* (Washington: CBO, December 2007).
[20] See CBO, *Evidence on the Costs and Benefits of Health Information Technology*, May 2008; CBO, *Research on the Comparative Effectiveness of Medical Treatments*, December 2007; and CBO, *Budget Options Volume I: Health Care*, December 2008.
[21] Louise B. Russell, "Preventing Chronic Disease: An Important Investment, But Don't Count On Cost Savings," *Health Affairs*, January/February 2009; 28(1): 42-45.
[22] CBO, *Designing a Premium Support System for Medicare* (Washington: CBO, December 2006).