Cost Containment in the Senate Leadership Bill: The Point is to GET STARTED

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Summary and Introduction

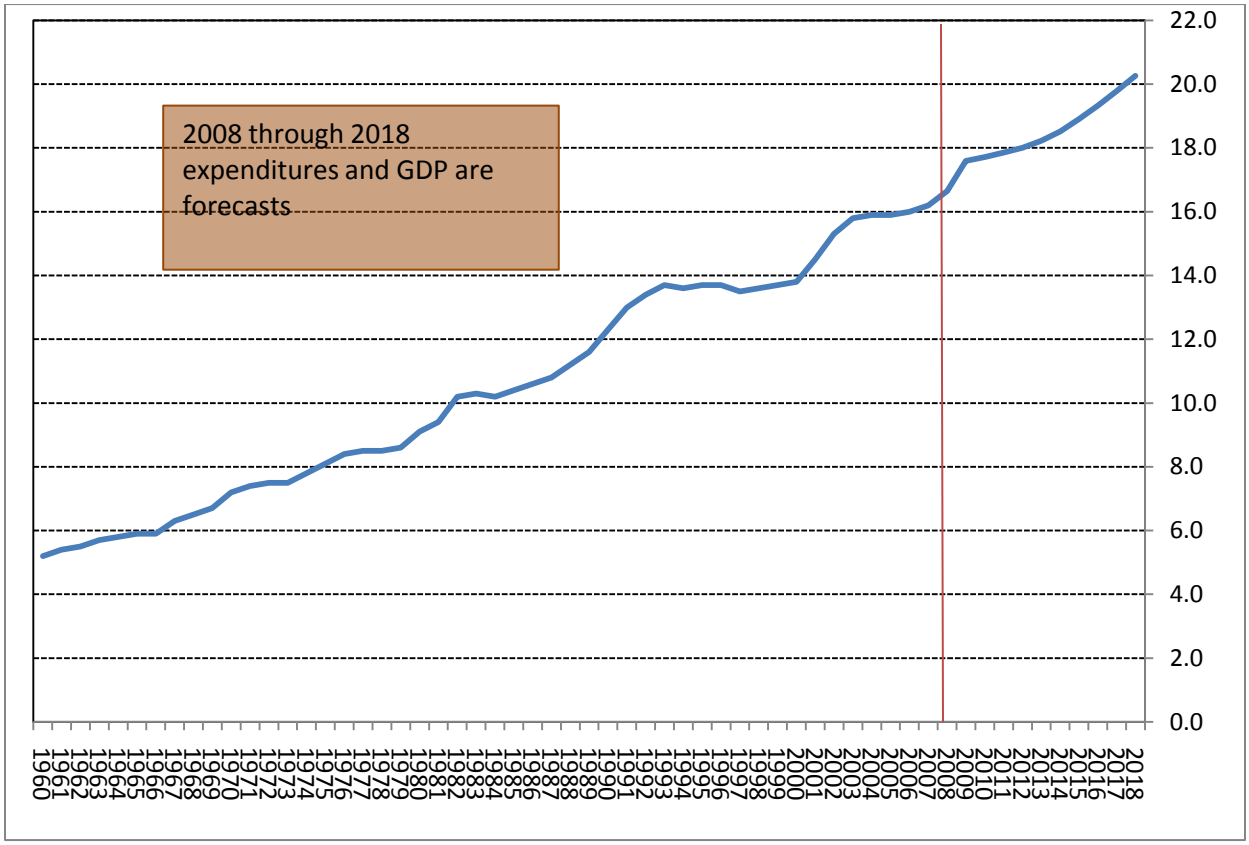
As Congress moves forward with health reform legislation, the idea of "cost containment" or slowing the growth of healthcare costs has become a hot button issue for many inside and outside the process. At its core, the concern is that most of the cost containment measures focus on the public programs (Medicare and Medicaid) and do little to change the overall cost structure of the healthcare system. Currently, health care providers are paid a fee for every service they perform. This "fee-for-service" structure gives incentives for more medicine rather than better medicine. Critics argue that without legislation that overhauls or eliminates this model—health care costs will continue to grow at an unsustainable rate.

To help frame the discussion, this brief will first look at growth in health care costs over time. Then, to pinpoint what we can reasonably expect from cost containment, we will compare the savings anticipated in the House and Senate bills to other economic growth rates. As it turns out, cost containment helps slow growth, but it is not the silver bullet many are hoping for. Finally, we will provide a brief assessment of the cost containment provisions for the public and private sectors Senate bill as well as how these provisions are meant to work together to reduce healthcare costs. As we analyze these provisions, it is important to remember that these are first steps towards changing the incentives and cost structures within one of the largest sectors of the US economy. The design and goals of these provisions have been discussed at a theoretical level by health economists for years—however there has been very little practical application. Even among experts there is a lot of uncertainty about how these provisions can be implemented and what results we can expect. For this reason, we feel that the approach outlined in the Senate bill in particular, that creates a number of cost containment pilot projects is the measured approach needed. As a recent New Yorker article pointed out, health reform has much in common with the agricultural reforms passed at the beginning of the 20th century.[i] The legislation that passed Congress during that process began as a series of pilot projects—which had the effect of transforming the country's economy. Health reform has the potential to do the same around our mounting cost challenges.

Background

Cost containment has been a centerpiece of national healthcare reform from the beginning—and for good reason. Healthcare in the United States is costly, and over time those costs have risen roughly three times faster than wages. The Centers for Medicare and Medicaid Services (CMS) are responsible for tracking health expenditures at the national level and they have found that in 2007, Americans spent $2.2 trillion dollars on healthcare, or 16.2% of the nation's gross domestic product (GDP). To put it simply, for every dollar the economy created, 16.2 cents went to healthcare costs. When CMS started keeping track back in 1960, health expenditures made up $27.5 billion or 5.2% of GDP. Even in 1983, (the year that Arizona joined Medicaid, the last state to do so) health expenditures were only $365 billion or 10.3% of GDP. **Figure 1** provides a time series look at health expenditures as a percent of GDP back to 1960, as well as growth projected by CMS through 2018.

Figure 1—US Health Expenditures as a Percent of GDP, 1960-2007 and Forecast for 2008-2018

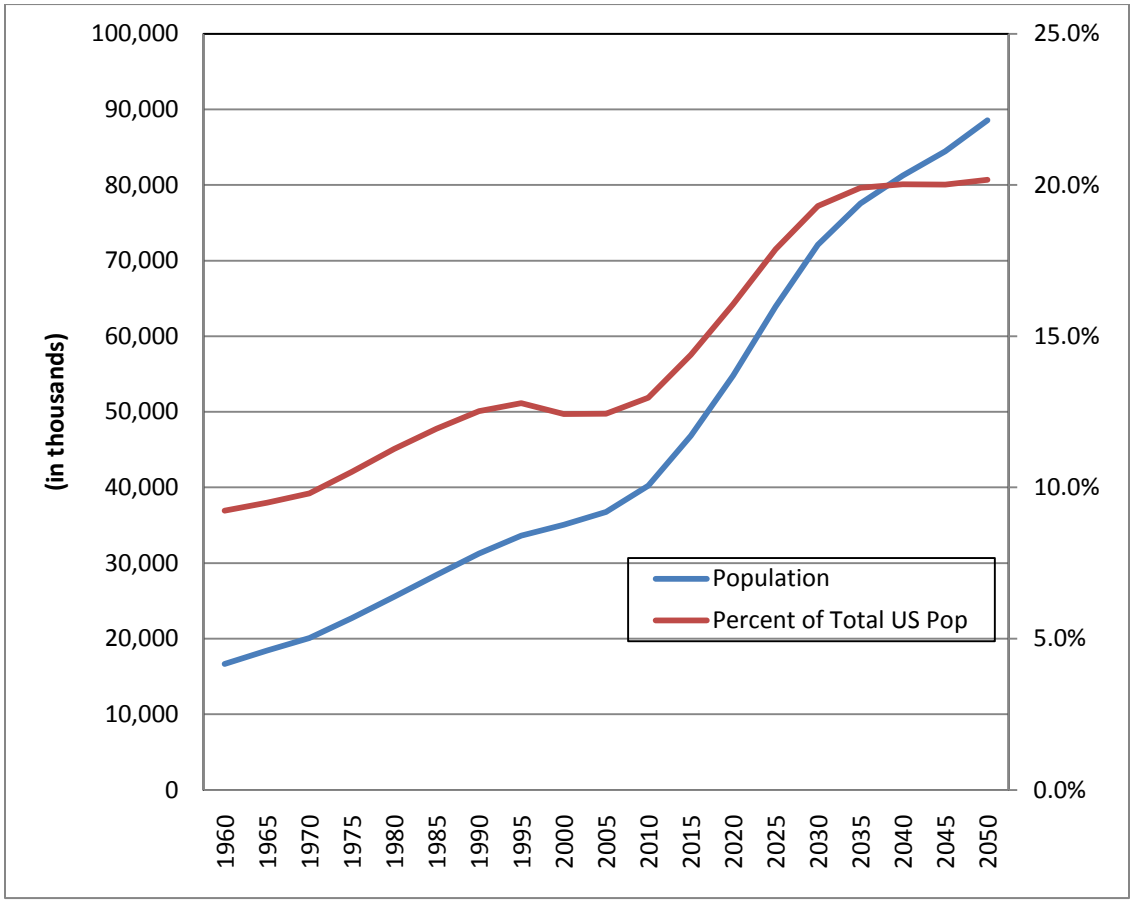


Source: US Department of Health and Human Service, Centers for Medicare and Medicaid Services, National Health Expenditures series

Since the inception of Medicare and Medicaid in 1965, public health expenditures as a percent of total health expenditures have expanded rapidly. In 2007, public health expenditures were 46.2% of all health expenditures and are forecast to reach the 50% level between 2015 and 2016. While public expenditures include government spending on healthcare for military personnel as well as public health agencies such as the Centers for Disease Control (CDC) and the Food and Drug Administration (FDA), the bulk of public spending (73.4% of total public expenditures in 2007) is for Medicare and Medicaid.

The growth in Medicare and Medicaid, both historically and going forward, has its roots in both the supply and demand sides of the economic equation. First, these programs have expanded considerably since their inception—both in terms of services provided and eligibility. Recent examples of each include Medicare Part D—the prescription drug benefit and the creation of the State Children's Health Insurance Program (SCHIP), a portion of which is financed with Medicaid dollars. Second, demand for these programs shows no sign of slowing down. As the over age 65 population becomes a larger and larger percentage of the total U.S. population, the demand for Medicare will increase proportionally as well. **Figure 2** shows the growth of the age 65+population from 1960 to 2050, when one in five Americans will be age 65 or older.

Figure 2—US Population Age 65 and Over and as a Percent of Total Population, 1960-2050



Source: US Census Bureau, Population Estimates Series and Population Projections Series

Facing this large uptick in demand, Medicare must be the frontrunner in driving down costs. In order to make the broadest possible impact, cost containment measures need to focus on those areas in which there are the largest opportunities for savings. As identified by a group of experts led by Alan Gruber of Stanford University, these measures need to include "aggressive tests" of payment reform as well as incentives to providers to better coordinate care in ways that move the system from the fee-for-service model to an *episode-of-care* model. The group also stressed the need for an independent Medicare Commission that would be responsible for developing cost containment measures that would not result in rationing of care or cost shifting to beneficiaries.[ii]

As time goes on, cost containment will become increasingly critical to the viability of the public programs. For the bulk of Americans who receive their healthcare through the private market—cost containment ostensibly means lower health insurance premiums, lower out-of-pocket costs and hopefully, more disposable income to help stimulate the economy.

The shorthand phrase, or cliché, that economists and policymakers are using to characterize efforts to drive down costs is "bending the curve." While everyone is talking about steps to accomplish this, it is a rather ambiguous phrase. How much can policymakers really bend the curve and what does that look like in terms of spending growth? Related to this—what are the estimated cost savings in the current bills?

Bending the curve—what is realistic?

What is achievable through cost containment measures? The Congressional Budget Office (CBO) estimates the House version of the healthcare reform bill would save $398 billion over a 10 year period, while the Senate version would yield savings of $435 billion. It cannot be stressed enough that these savings are only calculated by CBO for the public programs—Medicare and Medicaid. Since government only pays the bills for the public programs and therefore can only affect cost savings within the public programs, CBO's primary responsibility is to review legislation directly related to those programs. Any and all cost savings that happens within the private sector is generally beyond the scope of CBOs analysis. Thus they are not calculated in the overall savings estimates. This key point, we believe, has been lost to the critics that say there aren't enough cost containment measures within either version of the bill. CBO has endeavored to calculate the potential impacts of the bills on health insurance premiums, providing a starting place to gauge the impact of health reform on the private marketplace[iii]. Beyond this however, there are at this point too many unknowns around how various parts of the private health system will react to reform. This underscores the need to get started on the reform process, if not for any other reason than to determine what works—and what does not.

Another key point regarding cost savings within the private healthcare sector is that businesses within the sector such as insurance companies and for-profit providers are under no obligation to pass savings onto the general public. These and other businesses may realize these savings and pass them on in the form of profits to shareholders or use them for purposes other than reduced costs to consumers or employers. We could potentially see cost savings from the public programs and yet still see overall health expenditures rising because of such actions within the private healthcare sector.

Figure 3 presents a series of calculations designed to provide context around the cost savings achieved in the House and Senate bills. The row labeled "Current Projections" shows how much health care expenditures are projected to be in 2018 without reforms--$4.35 trillion dollars as well as the percentage that represents of GDP. Under the House version of the bill, savings in 2018 are projected to be $88 billion and savings over 10 years of nearly $400 billion. The Senate version provides a savings of $99 billion in 2018 and an overall savings of $435 billion.

Figure 3—A Comparison of Cost Containment Measures in the House and Senate bills

In $ billions	2018 National Health Expenditures	Savings in 2018 compared to Projected NHE	Total Savings over 10 years	2018 Health Expenditures as a % of GDP
Current Projections	$4,353.20	$0.00	$0.00	20.3
House Bill	4,265.20	88.00	398.00	19.9
Senate Bill	4,254.20	99.00	435.00	19.8
NHE	4,268.85	84.35	415.14	19.9
CPI 1960-2008	4,248.54	104.66	581.50	19.8
Commonwealth	4,109.20	244.00	1,589.50	19.1
CPI 1990-2008	3,985.34	367.86	2,737.55	18.6

Source: US DHHS, CMS National Health Expenditures series, CBO analysis of H.R. 3962 and Senate substitute for H.R. 3590, US Bureau of Labor Statistics, Consumer Price Index (CPI-U) series and "Bending the Curve" a report by The Commonwealth Fund Commission on a High Performance Health System published 12/18/2007. Calculations for the rows labeled NHE, CPI 1960-2008 and CPI 1990-2008 by author.

Underneath the rows that detail the cost savings within the two bills, there are three additional rows of figures. These figures are for reference only, to provide a deeper insight into the magnitude of the cost containment

task. First, we examined the national health expenditure time series for the smallest annual increase. This happened in 1995-1996, when health expenditures grew by 5.1%. We then asked what the cost savings would look like if policies could limit annual growth going forward by 5.1%. So, between 2008 and 2009, healthcare costs would only grow by 5.1% and again between 2009 and 2010, and so on through 2018. This scenario results in higher expenditures in 2018 than anticipated in either the Senate or House bills. Remarkably, the 10 year savings achieved is less than that of the Senate bill. Either version of the bill could contain cost growth better than measures taken in the late 1980s and early 1990s when HMOs were viewed as the key component to containing costs.

Bottom line—Both versions of the bill contain costs better than we've been able to achieve to this point.

Since health care expenditures have typically grown faster than the overall rate of inflation, we asked what health expenditures would look like in 2018 if we implemented policies to bring the cost growth rate into line with general inflation. From 1960-2008, inflation in the U.S. has grown at an average annual rate of 4.6%. If we could slow health expenditure growth to that rate, the outcome in 2018 would be slightly better than that projected under the House or Senate bills, by about $6 billion during 2018 and $147 billion overall. However, health expenditures would still consume 19.8% of GDP under this scenario.

Bottom line—Cost containment provisions in the Senate bill come closest to slowing down health care inflation to somewhere near that of overall inflation.

To this point, our analysis has focused solely on the savings from cost containment provisions in the public sector. A report published by The Commonwealth Fund Commission on a High Performance Health System calculates savings from cost containment provisions in both the public and private sectors[iv]. Were these recommendations implemented in their entirety, they would result in savings of $1.5 trillion over the 10 year period.

Bottom line—Real cost containment can only happen with the full engagement of the private health care sector.

The last question we asked was what would health expenditures look like if policies could turn the growth rate negative? How much would that reduce overall expenditures and expenditures as a percent of GDP? To calculate what this might look like, we used the average annual growth rate of the Consumer Price Index since 1990—which is actually negative at -1.9%. By imposing this rate on health expenditures, we can see the curve shift a little. In 2018, expenditures are slightly below $4 trillion dollars and over the 10 year period, we've saved $2.7 trillion dollars. Yet, as a percent of GDP, health expenditures are still at 18.6%, still significantly above the 16.2% in 2007.

Bottom line —Even with aggressive cost containment policies health care costs are going to continue to consume a larger portion of our nation's output due largely to the graying of America.

While these figures illustrate the enormity of the task of cost containment, by no means do they suggest that we should not make the effort. Every scenario above shows better results than doing nothing. It is also important to remember that the 10 year horizon presented is a very short timeline. Changes that may yield small results in the beginning can have large impacts further down the road. Healthcare economists across the political spectrum have identified four key provisions that Congress must include in its final legislation in order for cost containment to succeed.[v] These are—deficit neutrality, an excise tax on high-cost (a.k.a. "Cadillac") health insurance plans, an independent Medicare commission to implement long-term cost containment within

Medicare, and delivery system reform. As the cost containment provisions in the Senate version of the bill seem most likely to prevail, the focus of the rest of this report will be on what those do to bend the cost curve.

Deficit Neutrality in the Senate Bill

As stated in their November 17th letter, Garber's group of economists feels that budget neutrality and/or deficit reduction must happen within the legislation.

> *"Fiscally responsible health reform requires budget neutrality or deficit reduction over the coming years… Covering tens of millions of currently uninsured people will increase spending, but the draft health reform legislation contains offsetting savings sufficient to cover those costs and the seeds of further reforms that will lower the growth of spending. Deficit neutrality over the first decade means that, even during the start-up period, the legislation will not add to our deficits. After the first decade, the legislation should reduce deficits."*[vi]

As *scored* (calculated) by the Congressional Budget Office, the Senate bill reduces the deficit by $130 billion over the 10 year period 2009-2019, with much of those savings realized from 2009 to 2014.[vii] The Senate bill also increases both federal revenues and spending. In order to achieve the $130 billion reduction to the deficit—CBO calculates the Senate bill will have to come up with $492 billion (or 2.8% of projected public spending) in cost savings over the 10 year period. To achieve deficit neutrality, all the cost savings measures contained in the bill will need to total $362 billion over the 10 year period. Either number is an ambitious goal.

Excise Tax

No one likes taxes—especially new taxes. But, as the Garber group points out, the excise tax on high-cost health insurance plans is not just meant to raise revenue to pay for health reform. It is meant to change behavior. This argument gains force when examining the CBO scoring for the tax relative to other revenue increases in the Senate bill.[viii] This excise tax is estimated to raise $149 billion over 10 years—most of that coming in 2017-2019, once reform measures are fully implemented. Other revenues are estimated at $336 billion. As explained in the letter, the value of this excise tax is two-fold.

> *"The excise tax will help curtail the growth of private health insurance premiums by creating incentives to limit the costs of plans to a tax-free amount. In addition, as employers and health plans redesign their benefits to reduce health care premiums, cash wages will increase."*[ix]

It is important to note that the economists' optimistically assume that any savings from reduced premiums will be passed on to employees as wages. The original Senate Finance Committee bill estimated that reducing premiums would generate $300 billion in potential "wages" to employees during the 10 year period. However, this number is extremely fuzzy and is based on a lot of assumptions that have yet to be proved—hence the reason that CBO did not place a dollar figure on it for the bill presented by Reid on November 17th.

Independent Medicare Commission

As currently proposed, the Medicare Commission would be limited to seeking cost savings only within Medicare (not all public programs) and would only meet if Medicare per capita spending exceeded growth in certain economic indicators, the likelihood of which is very small.[x] Other operating rules of the Commission present further cause for concern. These include:

- Hospitals and hospices are exempt from cost containment recommendations until 2019, yet hospitals alone account for 37% of costs in publicly funded programs.
- As presently outlined—the Commission has no authority to implement reforms without Congressional approval. Yet, past attempts to rein in Medicare costs have been thwarted by Congress' oversight.
- The Commission is limited to oversight of Medicare alone, rather than all public programs (Medicaid and SCHIP), limiting efforts to implement cost savings measures found in one program to another.
    - This arrangement may adversely impact low-income seniors who are eligible for both Medicare and Medicaid
    - There are provisions for an innovation center within Center for Medicare and Medicaid Services that is charged with cost containment, but the Senate bill is not clear about how these two entities will work together—if at all.

As the Garber group pointed out, in order for this commission to fulfill its role and really tackle the issue of cost containment in the public programs, it should have the following elements:

- Be completely autonomous in finding and implementing cost containment provisions
    - Or at least answer only to the executive branch
- Look at the full panoply of Medicare provided services
    - The legislation already states that cost containment cannot be achieved through rationing, increasing revenues (such as new taxes), changing benefits or eligibility. Yet, these are the elements necessary to protect the Medicare population
- Look beyond Medicare and make recommendations for cost containment within all public programs. [xi]

Payment and Delivery System Reforms

How providers receive payments, for what services and the functioning of medicine as a business are the focus of payment and delivery reforms. This is where economists feel that Congress has the largest opportunity to bend the curve—not through mandates or re-writing the business model, but through incentivizing behavioral changes. For such reforms to work, there are a few key elements that must be included:

- moving from a fee-for-service to an episode-of-care model;
- bundling payments for care, especially of chronic conditions like diabetes and asthma;
- creating "medical homes;"
- reducing hospital readmissions due to poor care or because of hospital acquired issues, such as infections.

Here, too, the Garber group raises the concern that much of the current Senate bill does too little to address these elements. Provisions within the bill push out the horizon for implementing payment and delivery reform to 2018 or 2019. Additionally, the scope of payment bundling does not include chronic conditions and the limitations on penalties for hospital readmissions hamper meaningful reform. [xii]

Of interest to Utahns, payment and system reform are areas in which our state's healthcare system excels. In the next report in this series, we will outline how Utah achieves its successes in these areas. Going forward, these successes can inform the debate as well as provide models for other states.

CONCLUSION

There is an old saying about politics that goes something like this—*"never watch sausage or legislation being made."* In the case of health reform legislation, this is particularly true. In the time it has taken to write this report, no fewer than three slates of amendments have been introduced in the Senate. It is still unclear what the final result will look like. This being said, there are still two points that remain clear. First, health care reform, especially the affordability provisions, cannot be addressed without the participation of the federal government. Second, this is the closest we have come, as a nation, to overhauling the healthcare system since the inception of the public programs in 1965. While the end result coming out of Congress might not be ideal, it will be a start towards addressing persistent challenges hampering our ability to deliver cost-effective care. But it will only be a start. Everyone with a stake in the discussion—consumers, providers, health insurance companies, lawmakers and program administrators need to continue finding ways to make the system work better and at a lower cost.

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[i] The New Yorker article is available at
http://www.newyorker.com/reporting/2009/12/14/091214fa_fact_gawande?currentPage=1

[ii] On December 7th, 2009--Dr. Garber and his colleagues issued a letter to Senator Reid. It raises concerns that the Senate bill is "watering down" the necessary elements. A link to the letter is provided by Time magazine and is available at
http://timeswampland.files.wordpress.com/2009/12/12-7-09-economists-letter-to-harry-reid1.pdf
[iii] The CBO letter to Senator Bayh with the analysis of the impact on premiums under the Senate bill is available at
http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf

[iv] The report from The Commonwealth Fund Commission is available at
http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Dec/Bending-the-Curve--Options-for-Achieving-Savings-and-Improving-Value-in-U-S--Health-Spending.aspx
[v] The New York Times published a reprint of the November 17, 2009 letter from Garber, et al. It is available at
http://economix.blogs.nytimes.com/2009/11/17/economists-letter-to-obama-on-health-care-reform/

[vi] Ibid
[vii] CBO's scoring of the Senate bill as introduced by Senator Reid is available at
http://www.cbo.gov/ftpdocs/107xx/doc10731/Reid_letter_11_18_09.pdf

[viii] Ibid

[ix] The New York Times published a reprint of the November 17, 2009 letter from Garber, et al. It is available at
http://economix.blogs.nytimes.com/2009/11/17/economists-letter-to-obama-on-health-care-reform/
[x] From 2013 to 2018, the growth rate of per capita Medicare spending would have to exceed the moving five-year average of the overall Consumer Price Index (CPI-U) and the medical inflation component of the CPI (CPI-M) The Kaiser Family Foundation provides a side-by-side comparison is available at http://www.kff.org/healthreform/sidebyside.cfm

[xi] Garber et al; http://timeswampland.files.wordpress.com/2009/12/12-7-09-economists-letter-to-harry-reid1.pdf

[xii] Ibid