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‘Super Committee’ Looks To Health For Savings To Reduce Deficits

But, as with health care reform, Democrats and Republicans face off across a wide philosophical gulf.

BY STEPHEN LANGEL

Washington’s summer of 2011 debate over raising the federal debt ceiling gave birth to a new congressional “Super Committee”: the Joint Select Committee on Deficit Reduction. The twelve-member, bipartisan panel is required to reach agreement on plans to decrease federal budget deficits by $1.2 trillion between fiscal years 2012 and 2021—in addition to the $2.1 trillion in cuts over the same period as agreed to last August.

As the committee sifts through the options, it will clearly focus on health care, largely through proposed reductions in spending growth in Medicare, Medicaid, and other health programs. It is far less certain whether Democrats and Republicans can reach agreement on such measures—let alone deliver a broader overall package of savings in the politically charged run-up to national elections in 2012.

Health spending is a clear target for the same reason invoked by the infamous Willie Sutton. Because the US government has in effect promised to spend $100 trillion more on Medicare and Medicaid than it is scheduled to collect in taxes, Massachusetts Institute of Technology economist Jonathan Gruber notes, “spending on these programs must fall, or politicians must prepare themselves for massive tax increases in the long run.” And as the report from the National Commission on Fiscal Responsibility and Reform pointed out earlier in 2011, by 2015 projected federal tax revenues will be able to cover only Medicare, Medicaid, Social Security, and interest on the federal debt.

More federal tax revenues could be part of the answer, but not one acceptable to most Republicans. So with Social Security probably off the table for political reasons, the knives are out for health programs.

In mid-September, President Barack Obama proposed a $3 trillion package of savings that included $320 billion in Medicare and Medicaid savings. Although the bulk of cuts involved reduced payments to hospitals and other providers, the administration didn’t spare beneficiaries—proposing, for example, that higher-income Medicare enrollees pay even higher premiums than they do now for their physician and drug coverage under Medicare Parts B and D.

Predictably, seniors’ advocacy groups have loudly objected. “AARP reiterates its strong opposition to any proposals that would raise costs or cut the hard earned Medicare benefits that millions of seniors depend upon every day for their health and retirement security,” said AARP executive vice president Nancy LeaMond in a statement issued after the president’s plan was released.

Perhaps not surprisingly, almost all of President Obama’s proposed Medicare changes are designed to begin in
2017—safely into the tenure of the next president. There’s no question that the options before the Super Committee are politically distasteful and that the broader public, not just providers, would feel the pain. Here is a list of proposals that have been submitted by the president or that health policy experts think will make it into the final package—assuming there is one.

**Higher Costs For Medicare Beneficiaries**

President Obama’s proposal to increase higher-income Medicare beneficiaries’ premiums for Parts B and D builds on the income-related premiums in the current program, which affect single individuals with incomes of more than $85,000 and couples with incomes of more than $170,000 and are calculated on a sliding scale. About 5 percent of Part B Medicare beneficiaries now pay those higher premiums, rising to 14 percent in 2019. About 3 percent of Part D beneficiaries pay those higher premiums right now, rising to 9 percent in 2019.

Another controversial Obama proposal would attempt to capture savings in the Medicare spending for people who have private Medigap insurance policies (for background, see *Health Affairs’* Health Policy Brief at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=52). There is evidence linking Medigap coverage to greater use of Medicare services, particularly for those who purchase “first-dollar” coverage that shields beneficiaries from the effect of deductibles and coinsurance. Under the Obama plan, starting in 2017, new Medicare enrollees who buy certain Medigap policies with very broad coverage would pay a 15 percent surcharge to the government.

Aside from the Obama proposals, the Super Committee is also likely to consider other changes affecting beneficiaries. These could include modifying cost-sharing requirements for hospital and postacute care under Part A and physician and outpatient services under Part B. The Congressional Budget Office (CBO) presented several options for doing so earlier this year. One option would create a single annual deductible for both parts of the program—perhaps $550—and uniform coinsurance rates above that deductible. Because Part B currently has no deductible, the effect would presumably be to drive utilization down somewhat. The CBO estimates that the proposal could save as much as $93 billion from 2012 to 2021.

Such changes could be made more palatable for beneficiaries by putting a lid on what is now their unlimited liability for out-of-pocket expenses. Such a plan was, of course, at the heart of the short-lived Medicare Catastrophic Coverage Act passed in 1987 and then repealed two years later. This time around, a ceiling of perhaps $5,500 could be set on annual out-of-pocket spending, health policy analysts say.

**Cuts To Provider Payments**

Having agreed to constraints on Medicare payment that helped finance the Affordable Care Act of 2010, hospitals have lobbied hard to escape further Medicare cuts now. With President Obama’s plan, they largely succeeded. The proposal focuses on savings from postacute care providers, including nursing homes and long-term care and rehabilitation facilities. These would see $42 billion in cuts over ten years.

The president also proposed cuts to Medicare special provider payments, including money spent to offset bad debt that providers accrue, support the extra costs of training physicians, and protect the financial viability of rural providers. These adjustments would save up to $35 billion over ten years.

**Savings On Drugs**

With the federal government expressly forbidden by law from negotiating drug prices in the Part D program, Democrats and a few Republicans have long looked for other ways to enable the program to capture drug discounts. The Obama plan proposes that manufacturers pay Medicare the same “rebates” for brand-name and generic drugs that they already pay Medicaid for beneficiaries who receive the Medicare low-income subsidy. This option is estimated to save $135 billion over ten years.

More broadly, the Obama administration is also pushing forward on its plan to shorten the period of “data patent exclusivity” on “biosimilar” drugs—in effect, generic versions of the complex molecule proteins, antibodies, and other biologic drugs that increasingly drive drug development and medical treatment. Although the Affordable Care Act limited exclusivity on brand-name biologics to twelve years, the Obama plan proposes to shorten it to seven years and to prohibit manufacturers from obtaining additional periods of exclusivity by making minor changes in product formulation. Earlier legislation created a pathway for biosimilars; it is expected to save tens of billions—and shortening the exclusivity period further could reap an additional $3.5 billion in savings to federal health programs over ten years.

**Major Changes In Medicaid**

President Obama proposed that the Super Committee consider a total of $66 billion over ten years in cuts to projected spending on Medicaid. Included in his package are further limits on the taxes that states levy on health care providers to finance their share of Medicaid costs—but then recycle back to providers in the form of higher payments.

Also in the president’s package is a proposed new formula for splitting Medicaid and Children’s Health Insurance program spending with the states. Beginning in 2017 the proposal would replace the different current matching formulas with a single blended match rate specific to each state—under an arrangement that automatically increases the federal payment to states if a recession forces a state’s Medicaid enrollment and Medicaid outlays to rise.

**Wishful Thinking?**

Many observers hope that the Super Committee will consider even more sweeping changes to Medicare and Medicaid. For example, Harvard economics professor David Cutler says he would like the committee to consider changing the entire structure of fee-for-service payment under Medicare to payment based not on volume, but rather on the quality of the outcomes. Under provisions of the Affordable Care Act, Medicare is now taking steps toward that objective—for example, in the form of value-based payment for hospitals, new payment arrangements to accountable care organizations. How-
ever, a wholesale shift in payment that took place sooner would transform the underlying entitlement structure, resulting in massive, long-term savings, Cutler says. “Do you want to do nickel and diming,” he asks, “or do you want to throw a ‘Hail Mary?’”

Douglas Holtz-Eakin, president of the American Action Forum, former chief economist for the Council of Economic Advisers under President George W. Bush, and director of the Congressional Budget Office from 2003 to 2005, agrees that more dramatic change is needed—particularly in Medicaid. He cites the plan backed by Republican governors under which states would decide their own levels of Medicaid spending, and the federal government would reimburse them according to a preset amount. However, no one really believes that a Democratic president and Senate would go along with a plan that, in their minds, would shred the federal-state safety net.

Other policy experts are hoping that the Super Committee will embrace major tax changes, because the panel has broad authority to propose new revenues in addition to calling for changes to any part of the federal budget. The Holy Grail would be narrowing or ending the exclusion from federal income taxation of employer-sponsored health insurance, now estimated to result in a loss of $250 billion in federal tax revenues annually.

Discussions of the tax exclusion are familiar to *Health Affairs* readers, but at this time in the nation’s fiscal history, the exclusion seems like especially bad policy, says Donald Marron, director of the Urban Institute–Brookings Tax Policy Center, who served as a member of the President’s Council of Economic Advisers under President George W. Bush. Not only do the benefits of the exclusion redound mainly to insured, upper-income taxpayers, he notes, but the evidence suggests that the exclusion leads to overuse of health care services.

Given the ongoing congressional impasse over raising taxes, major changes affecting health-related taxes seem unlikely for now. Marron and Robert Greenstein, president of the Center on Budget and Policy Priorities, also acknowledge that narrowing or ending the exclusion would be too unpopular with the public to be politically feasible now. Such changes are “extraordinarily difficult to pass in the real world,” Greenstein says.

The political difference of opinion over taxes is only one aspect of the larger philosophic divide that will hinder the work of the Super Committee, at least when it comes to health care. Lurking in the background to the budget debates is the fact that most Republicans insist that they fervently want to repeal the Affordable Care Act—a desire that Democrats are equally intent on thwarting.

It’s worth noting, however, that even the president isn’t beyond altering at least some provisions of the Affordable Care Act. For example, he proposes to trim the $15 billion Prevention and Public Health Fund created by the reform law by $3.5 billion over ten years, beginning in 2014—a step that the administration insists will still “allow for significant investments in prevention and public health activities.”

Time is also working against the committee. It is required by law to vote on a plan by November 23, and the entire Congress must vote on its proposal by December 23. That isn’t much time to assemble an action plan to tackle problems that have been building for years.

Under the Budget Control Act of 2011, if the Super Committee fails to reach an agreement by January 23, 2012, a “new” regime of automatic cuts in discretionary spending will eventually kick in—although they would only become effective in fiscal year 2013. These automatic cuts would largely spare most “mandatory” programs like Medicare; for example, cuts to that program would be limited to a 2 percent across-the-board saving in provider payments, freeing up $123 billion in savings between 2013 and 2021.

A number of providers acknowledge quietly that a payment cut capped at 2 percent could be a lot less harmful to their interests than some other options that the Super Committee may be considering—and thus that a panel stalemated on a broader agreement may be preferable to other alternatives.

Elsewhere, though, there is plenty of concern about having the panel fail to reach an agreement and having automatic cuts eventually go into effect. Health programs funded on the discretionary side of the federal budget, such as expenditures for the National Institutes of Health, are already facing cuts under previously negotiated discretionary spending caps—and in the context of automatic budget cuts, the pressures would only grow worse. Payment to providers would then be spared the worst cuts, only to see the nation’s basic biomedical science research enterprise pay a proportionally far greater price.

In the end, the panel may be a Super Committee, but it doesn’t have supernatural powers to bridge the political gulf dividing the country. And it’s also unlikely that it has the superhuman wisdom to craft the most intelligent health policies for the nation in the decade ahead.

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**NOTES**

Errata

RITTENHOUSE ET AL., AUGUST 2011, P. 1575 The analysis for this article included nineteen physician practices that should not have been included in the data set. Sixteen of these practices were duplicates, and three were ineligible according to the study’s inclusion criteria. The authors have removed these practices from the data set, and the corrected version of the article has been posted online. The online Appendix was affected by this error as well, and it, too, has been corrected online.

Removing these practices resulted in no differences in any of the article’s findings or conclusions.

LANGEL, OCTOBER 2011, P. 1819 This “Entry Point” article contains an inadvertent inaccuracy. On page 1820, the last two sentences of the first paragraph below the subheading “Higher Costs for Medicare Beneficiaries” should read as follows: “About 5 percent of Part B Medicare beneficiaries now pay those higher premiums, rising to 14 percent in 2019.2 About 3 percent of Part D beneficiaries pay those higher premiums right now, rising to 9 percent in 2019.” The article has been corrected online.