WebMemo
Published by The Heritage Foundation
No. 2498
June 19, 2009

The Senate Health Care Bills: $1.5 Trillion Sticker Shock

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Taxpayers are in for sticker shock.

Key committees in the both the House and Senate are racing to get health care reform bills to the floors of their respective chambers over the coming weeks. According to press accounts, however, a key, unresolved issue is how to pay for the expensive insurance subsidies many in Congress want.

For instance, the Kennedy–Dodd legislation would provide new insurance premium discounts to households with incomes below 500 percent of the federal poverty line. These subsidies would be phased in slowly over a number of years. Total federal costs for the program are expected to be near $1 trillion over 10 years, and costs for the bill might go as high $1.5 trillion depending on certain legislative specifications.

Dangerous Debt. Even more troubling is the expectation that costs will rise rapidly every year, even beyond the 10-year budget window. The Congressional Budget Office (CBO) has estimated that the annual cost of the insurance subsidy program in an early version of the Kennedy–Dodd bill would rise 6.7 percent per year after it is fully phased in. There is nothing in the legislation that would lead one to expect that pace to slow after the first decade.

Rapid cost growth for a health care entitlement is nothing new, of course. The federal government already runs two other health entitlement programs—Medicare and Medicaid—and they have been growing faster than per capita GDP growth virtually every year since their enactment in 1965. CBO has estimated that between 1975 and 2005, average per capita Medicare spending exceeded average per capita GDP growth by 2.4 percentage points, and Medicaid's "excess cost growth" rate was nearly as high (2.2 percentage points).

The rising costs of these entitlement programs are expected to push the federal government deep into dangerous levels of debt under current law. CBO projects that between 2010 and 2040, federal spending on Medicare and Medicaid alone will rise from 4.4 percent of GDP to 10.2 percent. That jump in spending—5.8 percent of GDP—exceeds the size of Social Security today. As matters stand, the bills emerging in Congress would add yet a third unfinanced health entitlement on top of the two already on the books.

Higher Future Costs. President Obama and his top health care policy advisors have pledged to work on a health care bill that "bends the cost curve" throughout the health sector. But the ideas that the Administration has put forward to date would either do little to slow rising costs or shift costs from public insurance to private premium payers.

First, the Administration has suggested a series of reforms that might be called "efficiency through government engineering." The idea is that the health

This paper, in its entirety, can be found at:
www.heritage.org/Research/HealthCare/wm2498.cfm
Produced by the Center for Health Policy Studies
Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002–4999
(202) 546-4400 • heritage.org

care system can be made more productive with government-led "investments" in health information technology, comparative effectiveness research, and prevention and wellness efforts.

Some of these concepts may in fact be meritorious. However, as CBO has stated on numerous occasions, absent more financial incentives for consumers or suppliers of medical services, these reforms alone are highly unlikely to produce much by way of savings.

The Medicare Mess. Furthermore, the government has been running the Medicare program for nearly half a century now, and it is clear from that record that the government has little capacity to drive efficiency in health care.

Medicare remains largely a fee-for-service insurance arrangement, which pays any licensed provider of medical services the same rate, regardless of the quality of the services delivered to patients. Repeated efforts to steer patients and services toward a higher-quality, lower-cost network of providers have failed. For instance, a long-running effort to buy durable medical equipment (DME) services for Medicare enrollees through a competitive bidding process was blocked by Congress last year. In its place, Congress passed an across-the-board payment cut for all DME suppliers to meet a budget target.

Recently, in an effort to put more "scoreable" cost-cutting ideas on the table, President Obama proposed to cut Medicare and Medicaid reimbursement rates for various health care providers by an additional $313 billion over 10 years. Those cuts come on top of the $309 billion the President proposed in his 2010 budget submission to Congress, for a total proposed reduction in Medicare and Medicaid of $622 billion over 10 years.

These proposed reductions in Medicare's reimbursement rates, many targeted at hospitals, are emblematic of how the government runs a health insurance plan. After much talk of trying to pay for value instead of quantity, the government is resorting to arbitrary, across-the-board fee cuts—which generally hit all providers, regardless of quality or cost—to meet budgetary goals.

Cost Shifting. Furthermore, these fee cuts are not likely to change the underlying cost structure in health care. In the past, when Medicare has cut reimbursement rates, providers of medical services have raised rates for private insurers to make up the difference. There is every reason to believe President Obama's proposed payment rate cuts would also lead to cost shifting.

The only reliable and lasting way to drive greater efficiency in health care is with cost-conscious consumers in a reformed marketplace. The Republicans' "Patients' Choice Act" would implement the reforms needed to build just such a marketplace. Americans would get fixed tax credits toward the purchase of insurance. If they used those credits to buy a more expensive plan, they would pay the cost difference. If, on the other hand, they enrolled in less expensive coverage, they would keep all of the savings too.

That is the way to provide strong financial incentives to insurers and the suppliers of medical services to reorganize themselves to be more efficient and patient-focused.

Bending the Cost Curve. The government can and should play an effective oversight role in such a marketplace, much as the Centers for Medicare and Medicaid Services have done with the new Medicare prescription drug benefit. But the government cannot bend the cost curve from Washington without resorting to arbitrary caps and price controls that always lead to a reduction in the willing suppliers of services and waiting lists.

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