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If Health Spending Controls Fail, What Are the Options?

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Abstract: *Imagine that the 2010 health reform legislation goes into effect as planned. If the skeptics are correct and it fails to control long-term federal health spending, what could a future Congress do to modify it? There are three approaches. Congress could (1) clamp down harder on prices and payments in a probably fruitless effort, (2) sharply expand the powers of the Independent Payment Advisory Board to ratchet back payments to providers of limited care, or (3) set a real and capped budget for federal health spending. If it took the third course, Congress would be faced with another choice: how to distribute the budget. Should it allocate funds to health care providers, as in Canada or the United Kingdom, which is the essence of rationing, or provide funds to households for them to decide how the funds will be spent?*

If the Patient Protection and Affordable Care Act (PPACA, or "Obamacare") actually goes into effect as scheduled, without major changes, a growing worry about the Act—among many other major concerns—is whether it will succeed in "bending the cost curve." Will its provisions succeed in slowing the rapid increase in federal health spending in the U.S.?

What would happen if the cost controls in the health reform legislation actually turn out to be ineffective? What options would we have at that point?

This is no abstract or hypothetical question. There are several reasons to be skeptical that the cost control features of the bill will ever be successful. For example:

- In the most recent trustees report for the Medicare program, Richard Foster, Chief Actuary for the U.S. Department of Health and Human Services (HHS), makes very clear that he is doubtful that the measures in the legislation will reach the projected targets for spending control. In an example of almost British understatement, he says that the figures in the report itself, which assume that the legislation goes into effect as planned, "do not represent a reasonable expectation for actual program operations."[1] He is not alone in feeling that there is a huge dose of wishful thinking in projections based on the orderly operation of the legislation.
- Among the things that raise most people's doubts is the assumption that the sustainable growth rate (SGR) fee reductions for Medicare physicians will

[1] Richard S. Foster, Chief Actuary, Centers for Medicare and Medicaid Services, "Statement of Actuarial Opinion," *2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, May 2001, p. 266, at *https://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf*.

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go into effect as scheduled, based on the 1997 Balanced Budget Act. Since Congress has routinely rolled back those fee reductions, it is reasonable to expect Congress to do the same in the future. That in itself puts a huge hole in the projected savings.

- There are also growing doubts that the new Independent Payment Advisory Board (IPAB) will be able to save the day by ratcheting down physician and hospital payments. There is a growing chorus of bipartisan concern about such an unelected body possessing this level of independent power. In all probability, either the IPAB will find its powers limited or it will be dismembered.
- The legislation includes a new long-term care program. Theoretically, the Secretary of HHS is to raise premiums sufficiently to assure that the program balances its books and does not add to the underlying cost of the legislation, but few imagine that future Congresses will allow the executive branch to raise premiums to the degree that would be required.
- There are also considerable doubts that the estimates of firms deciding whether to drop coverage and have employees join the subsidized exchanges are reasonable figures. The very large subsidies available to individuals in exchanges means that even small underestimates of the number of firms utilizing the exchange would have huge and negative impacts on spending under the legislation.[2]

For these and many other reasons, there is widespread doubt that the rosy spending and savings projections accompanying the legislation will prove to be true in practice. Given that overall deficits and debt in the federal sector keep rising, there will be considerable pressure to find better ways to strengthen the cost controls in the legislation in order to help address the chronic deficits and debt facing the country.

Improvements in efficiency for specific services and goods in an economy do not necessarily mean that total spending on those goods and services is reduced.

If that very probable scenario unfolds, what could a future Congress do? In practice, there are only three broad approaches that could be taken to yield substantial results. Each approach reflects both a different philosophy of the proper role of government and a different view of how government can operate effectively. The choice of instrument likely would depend on who controls Congress and the executive branch at the time Washington decided to ramp up cost control, but Americans should be very aware that the choice of approach would have big implications for the way in which the health care system is likely to evolve in the future.

Let us examine these options.

OPTION 1: THE ADMINISTRATIVE STATE STRATEGY—DIRECT MANAGEMENT OF THE SYSTEM

One view is that the best approach to reining in health spending is to influence the pricing and payment allocation of services in such a way that the system operates less expensively and, thus, that total spending is moderated. That is the primary approach incorporated into PPACA, so the idea would be to toughen its provision.

The presumption, both in PPACA and generally in the administrative state strategy, is that legislation or administrative action by the government can achieve the desired level of spending control by improving the efficiency of the health care system. It is a dubious proposition, as we have found before during the long history of using regulations to constrain spending, but nonetheless is a widely held view.

A conceptual reason to be skeptical is that improvements in efficiency for specific services and goods in an economy do not necessarily mean that total

[2] See Shubham Singhal, Jeris Stueland, and Drew Ungerman, "How US Health Care Reform Will Affect Employee Benefits," *McKinsey Quarterly*, June 2011, at *http://www.mckinseyquarterly.com/How_US_health_care_reform_will_affect_employee_benefits_2813.*

spending on those goods and services is reduced. Just consider the improvements and unit cost reductions in such things as cellular telephones or computers. Total spending has risen as efficiency has improved. Depending on underlying financial incentives and the level of demand for a service or product that is being improved, marginal reductions in unit costs can often be accompanied by a greater volume of spending. Based on our experience so far with health care, declining unit costs of certain medical products and services can often lead to an expansion of demand for those products and services.

So let us say that the current PPACA strategy does not hold down spending, yet Congress and the Administration choose to try to rein in spending through the option of strengthening the direct management of the health system. What would that look like?

Tighter rules. One feature is that we would expect to see a further increase in the direct regulation of physician fees and interventions than is already envisioned under PPACA. This would further circumscribe the freedom of action of providers in the health care market. The result would be such things as revisions in the so-called essential benefits package that must be made available by plans operating in the exchanges in order to bring federal costs down by reducing the services that will be covered—and thus subsidized. In addition, there would be further tightening of the payment levels in Medicare for physicians and hospitals, and also for pharmaceuticals.

In short, the result would be a ramping up of traditional price and payment controls, with the usual effects, such as an increase in the number of physicians withdrawing from certain programs or not taking new patients and avoiding certain services where they feel the return is insufficient or even negative.

More intervention in health delivery. The second feature of an enhanced administrative state strategy would be more aggressive management of the delivery system itself. That means the government using stronger incentives or regulations in a quest for more efficient forms of health care delivery than supposedly could be achieved by the private sector alone.

One of the efforts to do this in the health care legislation itself involved spurring the creation of accountable care organizations (ACOs), which are groups of health care providers who agree to payments being based on a cost and quality metric. This seems like a reasonable idea, but the Administration's effort to foster ACOs has hardly been going well. When the government issued its final rules on the creation of ACOs, they consumed 429 pages.

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Perhaps not surprisingly, few health care organizations thought it was worth enduring such red tape for the prospect of some money from the federal government. Nonetheless, if the Administration fails to achieve significant savings through one attempt to reorganize health care through this element of the administrative state strategy, it will simply have to turn to others.

The public option. A renewed push for a public health insurance option is likely to occur if other forms of reorganization fail to slow spending. For some proponents of the public option during the debate on the legislation, the aim may well have been simply to offer an alternative so that some Americans could choose a government-organized plan rather than a private one. But for many others, the aim was for the public option to be a foot in the door with the goal of achieving a single-payer system by crowding out its supposedly less efficient private insurance competitors. With the government setting up the rules for the competition and operating one of the plans, of course, there would be a high likelihood in this stacked deck that the public plan would be the winner.

So if costs do not begin to track down as PPACA is implemented, supporters of direct management will likely push again for a public option to be added to the health plan at the national level. If they are not successful in doing that, however, then the second-best approach for them would be to foster public options at the state level in order to open the door for a future nationwide option.

Some states, such as Connecticut, have already enacted public options at the state level. Through regulation and/or waivers, we could expect the Administration to create as favorable an atmosphere as possible for state public options to materialize.

The feds versus the states. As spending rises faster than anticipated, we can also expect the administrative state strategy to manifest itself in the balance of power between the states and the federal government, with Washington trying to exert greater control. That could presage a bitter struggle between proponents of what one might call "permissive federalism" and those who favor "restrictive federalism."

There seems little doubt that health exchanges will become a battleground between different visions of how to control health costs, as well as a subject of debate over the proper balance of power in the federal system.

One view of federalism—the permissive version—is that when the federal government creates a national program to address an issue, states should retain wide flexibility to experiment with strategies to reach the goals of the federal legislation to foster variety and innovation. The restrictive view, by contrast, essentially sees the states as the local agents of the federal government and tightly regulates how they carry out the federal program.

As pressures mount to bring health care spending under control, we will no doubt see an increased tension between these two views of federalism. We are already seeing it in the area of health exchanges under PPACA, with some arguing for a design that is determined primarily at the federal level and others balking at this and arguing for far greater discretion for states. There seems little doubt that health exchanges will become a battleground between different visions of how to control health costs, as well as, of course, a subject of debate over the proper balance of power in the federal system.

OPTION 2: THE INDEPENDENT COMMISSION APPROACH

The second approach to dealing with the problem of cost escalation involves trying to bypass the traditional decision-making in Washington. A common frustration among health policymakers is that it is very difficult for any health reform to make it through Congress without a host of compromises that undermine its likely effectiveness. So some of those original supporters of PPACA who felt that health spending might be insufficiently constrained under the legislation believed an independent body would be needed to keep spending on track.

Thus, the legislation creates an Independent Payment Advisory Board (IPAB). While limited to Medicare, the IPAB can respond to future over-budget spending by proposing a package of payment changes for health care providers. Only a vote by both chambers of Congress, including a supermajority in the Senate, can block the IPAB's recommendations from going into effect.

The IPAB does have limits on its powers. It can only regulate physician payments, though in 10 years it can begin to restrict hospital payments. It is able to regulate the administrative costs of other parts of Medicare. But it cannot, for instance, make structural reforms in the Medicare program or change eligibility. Nor can it actually utilize clinical effectiveness data to alter the payment schedule of particular specialties or institutions.

Beefing up the IPAB and extending its reach. It is very doubtful whether Americans will accept an independent board making decisions that will affect the

availability of services from their physicians or hospitals. There are already moves to restrict or eliminate it. Nevertheless, there are advocates of PPACA who believe that the correct way to bring costs down in health care is actually to strengthen the powers of the IPAB, and, indeed, that would be the logical extension of the commission approach.

For those who do want to strengthen the IPAB's control over the health care system, it could be strengthened in a number of ways. For one thing, it could be given more flexible powers than it has today. If you believe a commission should be empowered to ratchet back spending, then you would want to give it far more flexibility than simply regulating payments to physicians and hospitals.

If the current IPAB fails to be effective, there will likely be calls for it to have much wider powers to regulate volume as well as payment levels for certain areas of medicine and to propose major reorganization of health delivery.

Thus, if the current IPAB fails to be effective, there will likely be calls for it to have much wider powers to regulate volume as well as payment levels for certain areas of medicine and to propose major reorganization of health delivery.

Taking a step toward NICE. It can hardly be long, moreover, before the current "firewall" between examining clinical effectiveness data and actually using them will be reached in the case of the IPAB. The case will surely be made that it is irrational for a commission to make payment decisions and yet be precluded by law from actually considering clinical effectiveness in making those determinations.

Yet, logical and benign though that may appear, it is crossing the Rubicon. For once one goes down that road, one is essentially creating for Medicare the structure of management that we see in the British National Health Service's National Institute of Clinical and Health Effectiveness (NICE). Once that happens, we have a body that can engage in systematic control and rationing of the health care system as NICE is empowered to do.

Extending the IPAB to the private sector. If one goes further down the IPAB road to keep Medicare spending under control, it seems logical to many proponents of the commission approach to use the same tool to deal with costs for the non-elderly population—especially, they argue, because Medicare costs are to a large extent a product of underlying health costs.

Former Senator Tom Daschle, who at that time was expected to be Barack Obama's HHS Secretary, proposed such a strengthened commission in his 2008 book *Critical: What We Can Do About the Health-Care Crisis*. His view was to use a federal health board as a primary tool to achieve both reform and cost control in a reformed health system. In his book, Daschle suggests conditioning tax benefits for health care, such as tax exclusion, on a federal health board agreeing that the health services are effective.[3] Recently, a major deficit control proposal from the Center for American Progress argued—as a "failsafe" mechanism—for extending the IPAB to the private sector if federal health spending targets are not met.[4]

OPTION 3: PLACING A DIRECT LIMIT ON TOTAL PUBLIC SPENDING FOR HEALTH CARE

The third option is to tackle total public spending in health care directly by placing a firm budget on federal health spending, replacing the open-ended entitlement we have today for most federal health programs, especially Medicare. Today's Medicare "budget" is not

3 Tom Daschle, *Critical: What We Can Do About the Health-Care Crisis* (New York: Thomas Dunne, 2008), p. 179.

4 Michael Ettlinger, Michael Linden, and Seth Hanlon, *Budgeting for Growth and Prosperity: A Long-term Plan to Balance the Budget, Grow the Economy, and Strengthen the Middle Class* (Washington, D.C.: Center for American Progress, May 2011), p. 27, at *http://www.americanprogress.org/issues/2011/05/pdf/budget_for_growth.pdf.*

a budget in any normal sense of the word, where a decision is made about how much to spend on a program—for instance, as we do for defense. For Medicare, and for many provisions of PPACA, the budget is actually just a projection. Beneficiaries have a legal right to certain services, and providers send the bill to the government. We estimate what the total cost of those payments will be.

Moving to a fixed budget would in effect replace the largely "defined benefit" vision of federal health care—implicit in today's Medicare system and the new entitlements under PPACA—with a budgeted "defined contribution" model that is more like federal "discretionary" programs such as defense, education, or highways.

One of the key objectives of a defined-contribution health budget is to encourage greater cost-consciousness in order to encourage beneficiaries to seek better value for money. That would improve efficiency while keeping within the budget.

In 2008, I joined with a bipartisan group of budget analysts in proposing that long-term (perhaps 30-year) budgets be applied to entitlement programs such as Social Security, Medicare, and Medicaid.[5] That proposal would allow the budget for these programs to be reassessed every five years, but it would end the "auto-pilot" status of public funds for major health care programs and make the 30-year budget the default.

Let us say we were to adopt this approach to constraining federal health spending if—or, rather, when—PPACA fails to do so. If public funds for health care were subject to a real budget in this way, it would directly limit the future health spending trend line, but it would also raise a number of very important issues. One of them is that we would have to decide how to balance the financial risk between enrollees in a health program and the taxpayer (and future taxpayers).

Today's open-ended, defined-benefit programs place most of the financial risk on current and future taxpayers. Moving to a defined-contribution approach shifts more of the risk to the enrollee. For that reason, the formula by which the federal health budget is allowed to grow becomes a very important decision—and, indeed, is at the center of the debate today over proposals to establish a budget for federal health spending. That said, one of the key objectives of a defined-contribution health budget is to encourage greater cost-consciousness in order to encourage beneficiaries to seek better value for money. That would improve efficiency while keeping within the budget.

If such a limited budget were put into place, another decision would have to be made: What process do you use to allocate the budgeted amount? There are two ways to do that:

- **Distribute the budget to service providers.** One approach would be for the government to allocate funds directed to facilities and institutions (as, say, Canada and Britain do). The major decisions about the availability and type of resources would then lie with the government and providers.

  In this case, the beneficiary's services would depend on rationing decisions by those decision-makers. So Americans would have to ponder (1) whether the agency, board, or legislature would distribute budgeted funds in a manner they believed to be fair and effective and (2) whether their particular needs or concerns would be appropriately considered by those in control of the health budget.

  The Medicare provisions in PPACA are a version of this approach. PPACA actually establishes a budget for Medicare, and then it uses the IPAB to

5 Joseph Antos *et al.*, *Taking Back Our Fiscal Future* (Washington, D.C.: The Brookings Institution and The Heritage Foundation, April 2008), at *http://s3.amazonaws.com/thf_media/2008/pdf/wp0408.pdf.*

"distribute" it in the sense that the board's payment-level decisions would in practice decide which parts of the health system would receive funds and how much. It is a convoluted way of allocating funds to providers, but IPAB's decisions would do so.

- **Distribute the budget to individuals through a defined contribution.** The other, and very different, approach to distributing a budget would be to distribute it not to providers but to beneficiaries for them to use to choose the plans or services that they thought would best meet their needs. This is sometimes called "premium support," which is a form of defined contribution in which the budget is distributed as a payment toward the premium of a chosen plan.

The balance of financial risk between the enrollee and the government (i.e., taxpayers) in this method of budgeting depends on the way in which premium support is designed. In a "pure" premium-support system, the level of spending is decided and the level of services is the result. In a "pure" defined-benefit program, the eligible services are decided and the spending level is the result. But premium support mechanisms typically include features that would limit the financial risk to the elderly.

One way is to index the premium support amount in some way to actual medical costs or to some other cost index in order to limit the financial obligation of enrollees. By indexing the degree of financial support to a benchmark cost in this way, the level of budget uncertainty for the covered population is reduced (though, in turn, such indexing increases the balance of risk that is shifted to future taxpayers). Federal employees have a version of this system, since the government pays a percentage of their premiums up to a maximum, but that maximum is indexed to the cost of certain benchmark plans. Federal employees are responsible for the remainder of the premium associated with the plan they choose.

As an approach to allocating a budget, premium support is starkly different from the overarching philosophy of approaches that distribute money via providers or—as under PPACA—via a health board. Premium support puts the financial power, control, and decision-making for budgeted funds ultimately in the hands of beneficiaries. PPACA puts it in the hands of federal agencies and boards.

CONCLUSION

If PPACA fails to control long-term federal health spending—as seems very likely—the impact on future deficits and debt will be disastrous. A future Congress and Administration will have to decide what to do to get spending under control. There are really only three ways to do that:

- Use the tools of the administrative state to squeeze prices and payments in a probably fruitless effort to reduce total spending;
- Expand the powers of an independent IPAB-style commission to ratchet back payments to providers; or
- Set a specific budget for federal health spending.

For a real federal health budget, a separate choice must be made: Does the government allocate funds to health care providers—which is the essence of rationing—or does it provide funds to households for them to decide how the funds will be spent?

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