



CONGRESSIONAL BUDGET OFFICE  
U.S. Congress  
Washington, DC 20515

*Douglas W. Elmendorf, Director*

June 16, 2009

Honorable Kent Conrad  
Chairman  
Committee on the Budget  
United States Senate  
Washington, DC 20510

Dear Mr. Chairman:

In the absence of significant changes in policy, rising costs for health care will cause federal spending to grow much faster than the economy, putting the federal budget on an unsustainable path. This letter responds to your request for information about the features of reform proposals that would affect federal spending on health care over the long term.

As you noted, many experts believe that a substantial share of spending on health care contributes little if anything to the overall health of the nation. Therefore, changes in government policy have the potential to yield large reductions in both national health expenditures and federal health care spending without harming health. Moreover, many experts agree on some general directions in which the government's health policies should move—typically involving changes in the information and incentives that doctors and patients have when making decisions about health care.

However, large reductions in spending will not actually be achieved without fundamental changes in the financing and delivery of health care. The government can spur those changes by transforming payment policies in federal health care programs and by significantly limiting the current tax subsidy for health insurance. Those approaches could directly lower federal spending on health care and indirectly lower private spending on it as well. Yet, many of the specific changes that might ultimately prove most important cannot be foreseen today and could be developed only over time through experimentation and learning. Modest versions of such efforts—which would have the desirable effect of allowing policymakers to gauge their impact—would probably yield only modest results in the short term.

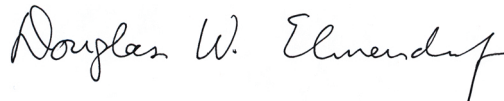
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Therefore, one broad long-range approach for reform that has drawn interest recently would combine specific policy actions—to generate near-term savings and provide experience that would lay the groundwork for future savings—with a mechanism or framework to impose ongoing pressure for achieving efficiencies in the delivery of health care. The effectiveness of that path would depend ultimately on the willingness of federal policy to maintain significant and systematic pressure over time and would require tough choices to be made. Without meaningful reforms, the substantial costs of many current proposals to expand federal subsidies for health insurance would be much more likely to worsen the long-run budget outlook than to improve it.

CBO does not provide formal cost estimates beyond the 10-year budget window because the uncertainties are simply too great. However, in evaluating proposals to reform health care, the agency will endeavor to offer a qualitative indication of whether they would be more likely to increase or decrease the budget deficit over the long term.

The attached analysis elaborates on these points. Please contact me at (202) 226-2700 if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Douglas W. Elmendorf". The signature is written in a cursive style with a large initial 'D' and 'E'.

Douglas W. Elmendorf  
Director

Attachment

Identical letter sent to the Honorable Judd Gregg.

## Health Care Reform and the Federal Budget

June 16, 2009

Because the Congress is now considering major legislation affecting health care and health insurance, the possible effects on the federal budget have received significant attention. To elucidate those effects, this analysis examines the budget outlook under current law; the likely budgetary effect of efforts to expand the scope of insurance coverage; the potential for reducing health care spending; the likely impact of specific changes in the health system; and mechanisms for engendering efficiency gains in health care over time.

### The Federal Budget Outlook

The federal budget is on an unsustainable path, primarily because of rapidly rising spending on health care. Federal outlays for Medicare and Medicaid have increased from 1 percent of gross domestic product (GDP) in 1970 to more than 5 percent in 2009; and the Congressional Budget Office (CBO) projects that under current policy, they will exceed 6 percent of GDP in 2019 and about 8 percent in 2029. Most of that increase will result from rising costs per capita, rather than from the aging of the population. As a result, the country faces difficult and fundamental trade-offs between limiting the growth of Medicare and Medicaid relative to GDP, accepting a continuing increase in taxes relative to GDP, and reducing other spending relative to GDP, possibly to levels not experienced in this country in more than 40 years.<sup>1</sup>

Moreover, serious fiscal imbalances are not a far-off problem. Under current law, CBO projects, Medicare's Part A trust fund—which pays for inpatient services, post-acute care, and hospice services and receives revenues principally from the payroll tax—will have insufficient funds to pay for all covered services starting in 2017. More broadly, federal debt held by the public is set to jump from 41 percent of GDP at the end of 2008 to more than 60 percent by the end of 2010, the highest level since the mid-1950s. Under CBO's March baseline projection, the debt would fall back below 60 percent of GDP in the second half of the decade, but the baseline assumes that currently scheduled increases in tax rates will be allowed to occur, even though policymakers seem intent on extending at least some of the 2001 and 2003 tax cuts. If those and all other expiring provisions were extended

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<sup>1</sup> The rapid growth of Medicare and Medicaid relative to the economy during the past four decades has been, in a sense, "financed" by a significant reduction in defense spending relative to GDP. Meanwhile, federal revenues and nondefense spending on other programs have grown about in line with the economy, on average. However, with health care spending continuing to shoot up and defense spending down to about 4 percent of GDP, the historical pattern cannot be repeated.

and the alternative minimum tax was indexed for inflation, the debt would continue to rise relative to GDP throughout the next decade, reaching 86 percent by 2019. Debt held by the public has not been that high since the years immediately following World War II.

For many observers and policymakers, that grim outlook for the federal budget during the next decade and beyond is an important motivation for crafting health care reform and making other policy choices in a manner that significantly reduces future deficits.

## **The Potential Impact of Expanding Health Insurance Coverage on the Budget Outlook**

The federal government's financing of health care will total more than \$1 trillion in 2009, all told. Federal outlays for Medicare and Medicaid are about \$700 billion; tax preferences for health care (especially the exclusion of premiums for employment-based health insurance from income and payroll taxes) amount to more than \$250 billion; and the federal government also pays for veterans' health care, public health initiatives, and other health programs. Already, those direct and indirect payments for health care account for nearly 60 percent of total health expenditures for the nation.

Many proposals to significantly expand insurance coverage would add to federal costs by providing large subsidies to help lower-income individuals and families purchase insurance. Those proposals would take several years to implement, but it is useful to consider the budgetary implications if they were up and running now so as to compare those costs to existing obligations. Depending on the specific policies selected, the added cost could be on the order of \$100 billion. In the absence of specific constraints on growth, the new spending (or revenue losses, if tax credits were used to provide subsidies) would probably increase over time roughly with the underlying costs of health care and, thus, would grow about as fast as spending on other federal health care programs.<sup>2</sup>

From that perspective, a large-scale expansion of insurance coverage would represent a permanent increase of roughly 10 percent in the federal budgetary commitment to health care. Improving the budget outlook therefore would require that other aspects of an initiative on health care reduce the federal resources

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<sup>2</sup> Spending growth in some other federal health programs depends on the aging of the population as well as the increase in age-adjusted health care costs. At the same time, the growth rate of spending on insurance subsidies would depend on the design of the programs. If lower-income households' costs for insurance were capped at a fixed share of income, then federal spending would rise faster than health care costs. Alternatively, subsidies for health insurance could be set to increase more slowly than health care costs, although that approach would make insurance more difficult for some households to afford over time. A reasonable assumption would therefore seem to be that, absent structural reforms, costs in all of the federal health programs would grow at roughly the same rate.

devoted to it by more than that amount (or that other federal spending or revenues be adjusted to accomplish the same end).

By themselves, insurance expansions would also cause national spending on health care to increase, in part because insured people generally receive somewhat more medical care than do uninsured people—notwithstanding the fact that some newly insured people would avoid expensive treatments by getting care sooner, before their illness progressed.<sup>3</sup> However, the rise in national spending on health care would be less than the increase for the federal government because some costs that are now paid by others would be shifted to the government (via the subsidies provided by the proposal).

Expanding insurance coverage would make it modestly easier to achieve some other reductions in national and federal spending on health care, but it would not alter the fundamental nature of these challenges. Several issues are relevant:

- Broader insurance coverage might lead to less cost shifting in the health care system, but that effect would probably be relatively small and would not directly produce net savings in national or federal spending on health care.

If more people had insurance, then the amount of uncompensated care would decline. Some government payments designed to pay for part of that care (such as “disproportionate share” payments to hospitals that treat many poor patients) could be trimmed accordingly. And, to the extent that costs of uncompensated care are currently shifted to private payers, some offsetting savings could arise. However, undoing any current shifts of spending among different payers would not change the growth rate of federal spending beyond the first few years.

Moreover, uncompensated care is less significant than many people assume. According to one study, hospitals provided about \$35 billion in uncompensated care nationwide in 2008—less than 2 percent of national health expenditures—and the estimates are much smaller for other providers.<sup>4</sup> The extent to which such costs are shifted to other payers is also uncertain; well-structured studies have found modest effects.<sup>5</sup> Further, some proposed expansions of insurance coverage would broaden eligibility for Medicaid, which might lead to additional cost shifting given Medicaid’s low payments to providers.

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<sup>3</sup> See Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), pp. 71–76.

<sup>4</sup> Jack Hadley and others, “Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs,” *Health Affairs*, Web Exclusive (August 25, 2008), pp. W399–W415.

<sup>5</sup> See Congressional Budget Office, *Key Issues*, pp. 112–116.

- In terms of the trajectory of spending, policymakers might be more willing to slow the growth in payments to health care providers—and providers might be more willing to accept slower growth—if they were not worried about the possible impact of slower payment growth on access to medical care for uninsured or underinsured people. (That effect could arise if cutbacks in payment rates for insured patients led doctors or hospitals to limit their provision of such care.) But budgetary savings from reducing payments to providers would not occur automatically with broader insurance coverage; they would arise only to the extent that legislation explicitly trimmed payment rates relative to levels under current law.
- Health care providers currently use resources looking for ways to receive payments for treating uninsured people. In addition, insurers currently use resources trying to determine the health of prospective customers and to avoid paying for treatments that address preexisting conditions. Expanded insurance coverage, together with the requirement that insurers provide coverage to all applicants and the elimination of restrictions on preexisting conditions (two features of many current insurance-market reform proposals), would save such resources.
- Currently, a significant share of the population moves in and out of insurance coverage during a year, which complicates efforts to provide effective prevention and wellness services. As discussed later, though, those services are less broadly effective at reducing health care spending than might be expected, and in any event, expansion proposals would not eliminate all of the churning that makes it harder to maintain continuity of care.
- Most expansions of insurance coverage that are under consideration would leave a moderate number of people uninsured, in part because some people would be ineligible for subsidies or would choose not to buy insurance even with large subsidies. Therefore, any current problems arising from the lack of insurance could be reduced but not eliminated.

It also bears emphasizing that if a reform package achieved “budget neutrality” during its first 10 years, budgetary savings in the long run would not be guaranteed—even if the package included initial steps toward transforming the delivery and financing of health care that would gain momentum over time. Different reform plans would have different effects, of course, but two general phenomena could make the long-run budgetary impact less favorable than the short-run impact:

- First, an expansion of insurance coverage would be phased in over time to allow for the creation of new administrative structures such as insurance exchanges. As a result, the cost of an expansion during the 2010–2019 period could be a poor indicator of its ultimate cost.

- Second, savings generated by policy actions outside of the health care system would probably not grow as fast as health care spending. Such would be the case for revenues stemming from the Administration’s proposal to limit the tax rate applied to itemized deductions and from proposals to tax sugar-sweetened soda or alcohol, for example.

Some policy options under consideration would yield savings that grew in tandem with health care spending—reducing the level of federal spending on health care but not affecting the measured rate of spending growth after the first few years. For example, the largest savings proposed in the President’s budget would arise from a decrease in payments to private health insurance plans operating under the Medicare Advantage program. If enacted, that change would permanently lower the level of Medicare spending, but it would probably not offset a noticeably larger share of the cost of an expansion of insurance coverage in the second 10 years than in the first.

Moreover, any savings in existing federal programs that were used to finance a significant expansion of health insurance would not be available to reduce future budget deficits. In light of the unsustainable path of the federal budget under current law, using savings to finance new programs instead of reducing the deficit would necessitate even stronger policy actions in other areas of the budget.

## **Potential Savings in Health Care**

Given those challenges, a health care reform package would need to incorporate very significant and fundamental changes in health care to truly improve the long-run budget outlook. Of course, projecting the effect of health policy changes into the distant future is very difficult, partly because predicting how the practice of medicine would evolve in the absence of those changes is difficult. Therefore, experts generally focus on ways to reduce the growth of health care spending over the next decade or two rather than over the very long run.

Policy changes that reaped significant savings quickly would lessen the medium-term impact on the deficit that a large-scale expansion of insurance coverage would have and could lay the groundwork for greater savings later. For example, if the growth rate of federal health care spending was trimmed by 1 percent per year during the next 20 years, the savings would roughly match the cost of an expansion of insurance coverage by the end of the decade and would exceed that cost in the next decade.

Significant savings seem possible because the available evidence implies that a substantial share of spending on health care contributes little if anything to the overall health of the nation. Therefore, experts generally agree that changes in government policy have the *potential* to produce substantial savings in both national and federal spending on health care without harming health. However,

turning that potential into *reality* in a sector that accounts for one-sixth of the U.S. economy is likely to be a prolonged and difficult process.

Perhaps the most compelling evidence about the extent of inefficiency in the health sector is that Medicare spending varies widely across different regions of the country, but the variation is not correlated with available measures of the quality of care or health outcomes. Researchers affiliated with the Dartmouth *Atlas of Health Care* have compared the Medicare spending for enrollees across the nation, controlling for demographic characteristics such as age, sex, and race. According to those researchers' calculations, Medicare spending could be reduced by almost 30 percent if outlays in medium- and high-spending regions were reduced to the average level in the lowest-spending decile.<sup>6</sup>

Comparisons of that sort are sensitive to the method of calculation. Some studies have expressed skepticism about the Dartmouth researchers' estimate.<sup>7</sup> CBO's own informal comparison of per capita Medicare spending in metropolitan areas, controlling for both the health status of individuals and the prices of health care inputs, implies that the savings from turning medium- and high-spending areas into low-spending areas might be roughly half of the estimate by the Dartmouth researchers. In addition, much less is known about regional comparisons of spending for and the health of patients outside the Medicare program. Still, most experts conclude that both formal analysis and extensive anecdotal evidence of regional differences in medical care and costs imply that a significant portion of spending on health care is not serving its intended purpose. Moreover, the delivery of health care in low-cost regions is not completely efficient now, so further savings might be achievable even in those areas.

Many experts think that transformational changes in health care financing and delivery could reduce the federal budgetary commitment to health by more than the 10 percent increase that would result from a large-scale expansion of insurance coverage. Achieving substantial and lasting savings, however, would require fundamental changes in the organization and delivery of health care. Examples of efficient care certainly exist today, with many individual health care providers and groups of providers offering both high quality and relatively low cost. Yet applying the methods of those efficient providers throughout the health care system cannot be accomplished through fiat or good intentions. Instead, the government controls two powerful policy levers for encouraging changes in medical practice:

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<sup>6</sup> See John E. Wennberg and others, "Geography and the Debate Over Medicare Reform," *Health Affairs*, Web Exclusive (February 13, 2002), pp.W96–W114.

<sup>7</sup> See, for example, Jack Hadley and others, *Variations in Medical Care Spending per Medicare Beneficiary: The First Stage of an Instrumental Variable Analysis* (report submitted to the Changes in Health Care Financing and Organization Program, Robert Wood Johnson Foundation, May 2006).



- Changes in Medicare could directly affect the efficiency of health care delivered to older and disabled Americans. Changes in payment rules could induce providers to offer higher-quality and lower-cost care (while ensuring that efficiency gains were shared by the government), and changes in the structure of benefits could give program beneficiaries stronger incentives to choose less costly care. Improved efficiency within Medicare is likely to have spillover effects on the efficiency of health care outside of the program.
- Changes in the tax exclusion for employer-sponsored health insurance can affect the efficiency of health care financed by the private sector, by giving workers stronger incentives to seek lower-cost health insurance plans. Those steps could well have spillover effects on Medicare.

Considerable consensus exists among experts about some types of changes that are likely to make the health sector more efficient: move away from a fee-for-service system toward paying providers for value, perhaps through fixed payments per patient, bonuses based on performance, or penalties for substandard care; provide stronger incentives for both providers and patients to control costs, through higher cost-sharing requirements or tighter management of benefits; and facilitate good decisionmaking by providers and patients by equipping them with more information about the effectiveness of different treatments and the quality of care delivered by different providers. Those changes in the flow of money and information would spur and facilitate other changes in the organization and delivery of health care.

Unfortunately, little reliable evidence exists about exactly how to implement those types of changes—especially at the level of specificity required for legislation. A recent letter to the President from a group of stakeholders in the health care industry reveals both the promise and the difficulty of achieving substantial savings through health care reform: Those stakeholders see increased efficiency as a critical goal of their organizations, and they agree that significant savings can be obtained. At the same time, many of the group’s proposals offer little detail about the specific changes necessary to achieve those objectives or the obstacles to their making the changes.<sup>8</sup>

## **Policy Options That Could Produce Budgetary Savings in the Long Run**

A number of specific reforms show great promise for reducing federal spending on health care over time without harming people’s health. However, at this point,

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<sup>8</sup> In particular, many of the proposals could be implemented without legislation, so they would not affect the budgetary scoring of a reform proposal, although they might affect CBO’s baseline projections of the costs of federal programs. See Congressional Budget Office, *Response to Questions About Health Care Industry Stakeholders’ Proposals*, letter to the Honorable Dave Camp (June 16, 2009).

experts do not know exactly how best to structure those reforms to achieve that goal. They will need to learn through experimentation. In the meantime, any particular approach to implementing such ideas might well yield less savings than hoped for or might raise concerns about the impact on the quality of care and on patients and providers.

CBO has analyzed a number of reform options in its recent publications, including creating so-called accountable care organizations, bundling payments to hospitals and other providers, providing additional information about effective medical treatments, expanding the use of preventive and wellness services and primary care, increasing cost sharing by patients, and modifying the tax treatment of employment-based health insurance.<sup>9</sup> When CBO evaluates policies, the agency aims to reflect the middle of the range of expert opinion about likely outcomes. For any particular policy option, CBO carefully reviews the relevant empirical evidence and examines the incentives that would be created to control costs and the factors that might limit the success of those incentives—as illustrated in the following discussion.<sup>10</sup>

One general point worth emphasizing is that reform options may have different effects on health and on the federal budget. Some policies, such as the increased use of preventive services and the coordination of care, would have clearer positive effects on health than on the federal budget balance. Other policies, such as certain changes in Medicare’s payment methods, would have a direct impact on federal spending, but their effect on health outcomes would be less clear. In part, that uncertainty reflects the difficulty of measuring the quality of health care—a situation that is likely to improve but which will take time to do so.

### **Create Accountable Care Organizations**

In Medicare’s traditional fee-for-service program, providers have little or no financial incentive to coordinate the care their patients receive across different treatment settings or to be accountable for the costs and quality of that care. One prominent example of a structure that may function better would be accountable care organizations formed by physicians and other health care providers. Under this model, providers would receive bonuses if they held down the total cost of the services their patients received during a year while also meeting requirements for the quality of the care; some versions would also impose penalties on doctors who did not meet those targets.

Proponents contend that such groups would coordinate care more effectively, which would improve patients’ health. In addition, the financial incentives would

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<sup>9</sup> See Congressional Budget Office, *Budget Options, Volume 1: Health Care* (December 2008) and *Key Issues*.

<sup>10</sup> See, for example, Congressional Budget Office, *An Analysis of the Literature on Disease Management Programs*, letter to the Honorable Don Nickles (October 13, 2004).

reduce the unnecessary use of specialists and expensive tests and procedures. Other initiatives, such as establishing “medical homes” for patients and implementing care coordination or disease management, could also be pursued more easily in this environment. Models of efficient health care today—including the Mayo Clinic, Kaiser Permanente, and Geisinger—are integrated delivery systems, and accountable care organizations have some of the same features.

A current demonstration project in Medicare (known as the Physician Group Practice demonstration) is testing similar approaches for providing care, using some of the integrated health systems noted above. However, the evidence for cost savings is mixed. Moreover, expanding this approach to physicians who are not already in an integrated system and may be reluctant to join one raises further issues. For example, challenges arise when trying to design programs that are voluntary for both enrollees and physicians, because both parties would generally need to expect some gain in order to participate—often at the government’s expense. Making such mechanisms mandatory, though, raises understandable concerns.

Given the novelty of these organizations, a number of questions remain unanswered about the structure and environment of them: How tightly would the groups need to be integrated in order to achieve cost savings? How should bonuses and penalties be set? Should payments to providers in the regular fee-for-service system be restrained in order to encourage them to join accountable care organizations? Although many experts agree that this approach should be vigorously pursued, several rounds of successive and significant changes and refinements in Medicare’s rules would probably be necessary to yield substantial budgetary savings.

### **Bundle Payments to Hospitals and Other Providers**

A number of experts have proposed bundling Medicare’s payments for hospitals and related services. (Payments are referred to as bundled when they cover multiple individual services.) These proposals illustrate a common issue in evaluating the budgetary effects of health care reform: Options that sound alike may have quite different cost consequences if they employ different degrees of aggressiveness in pursuing cost-saving goals.

CBO’s *Budget Options* volume included an option that would have hospitals receive a single bundled payment from Medicare for both the hospital services they provide and the care that their patients receive in a post-acute setting in the 30 days following their discharge. Hospitals already receive a fixed payment per admission, but this arrangement would provide hospitals with a new incentive to coordinate the care their patients receive after they are discharged and to economize in the use of post-acute care. The payment amount would be adjusted over time to capture part of the anticipated reduction in costs. CBO estimated that this option would save about \$19 billion over the 2010–2019 period.

The Commonwealth Fund also recently analyzed an option for bundling, one considerably more aggressive in reducing spending and altering incentives for providers.<sup>11</sup> Under that option, successively more inclusive bundling would be phased in: Initially, Medicare would bundle together payments for a hospital stay and any readmissions within 30 days; after three years, the bundling would be expanded to include post-acute care services as well; and after three more years, the bundling would also include payments for physicians in the inpatient setting and emergency room. Payment amounts would be reduced immediately upon implementation and then would continue to be restrained over time to reflect anticipated increases in efficiency from coordination among providers. The Commonwealth Fund estimated that this proposal would reduce federal spending by over \$200 billion between 2010 and 2020.

### **Provide Additional Information About Treatments' Effectiveness**

Concerns about the limited evidence that is available to determine which treatments are most effective for which patients has generated considerable interest in expanding the supply and use of information that compares the effectiveness of treatment options. (Limited evidence may help explain why the use of certain treatments and the types of care provided vary widely from one area of the country to another.) Many analysts believe that, because of the broad benefits that additional information could provide, the federal government should fund research on the effectiveness of treatments and should help disseminate the results to doctors and patients.<sup>12</sup>

Merely conducting and disseminating additional research is unlikely to have major effects on patterns of clinical practice or health care spending, however. For new research to have a significant impact, providers' financial incentives would need to be aligned with the results. For example, legislation could allow the Medicare program to limit or deny coverage for treatments that were found to be less clinically effective or less cost-effective than other interventions. Alternatively, Medicare could tie its payments to providers to the cost of the most effective treatment, or patients could be required to pay for at least a portion of the additional cost of less effective treatments. In all of these approaches, patients and physicians could still choose the course of treatment they preferred, but Medicare's payments would depend on the broad results of research.

Further challenges in reaping net savings from comparative effectiveness research arise from the cost of the research itself and from the lags in getting research under way, developing results (particularly if they depend on new clinical trials),

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<sup>11</sup> See Stuart Guterman and others, *Reforming Provider Payment: Essential Building Block for Health Reform*, The Commonwealth Fund, Commission on a High Performance Health System (March 2009).

<sup>12</sup> See Congressional Budget Office, *Research on the Comparative Effectiveness of Medical Treatments: Issues and Options for an Expanded Federal Role* (December 2007). In addition to evaluating medical treatments and procedures, such analysis could examine processes for delivering care.

and disseminating the findings. Although those challenges do not undermine experts' support for additional research, they explain why such research might not yield net budgetary savings within a 10-year budget window.

### **Expand the Use of Preventive and Wellness Services and Primary Care**

Many proposals to modify the health insurance system include provisions to expand the use of preventive and wellness services and the use of primary care. Those changes could improve people's health and the quality of care they receive. For example, vaccines can prevent the spread of diseases; screening tests may be able to detect illnesses at earlier and more treatable stages; and greater focus on primary care can foster healthier behavior and better coordination of care.

Although those policies could also lead to less spending on health care, the impact of specific preventive and wellness services on spending varies, depending on the disease being targeted and the population receiving the services. Evidence indicates that some preventive services (such as certain vaccines) reduce costs—that is, the savings for those who avoid getting sick exceed the costs of providing the intervention broadly. However, that outcome is far from universal: One study of the health and economic effects of preventive services found that only 20 percent of the services that were assessed yielded net financial savings.<sup>13</sup>

Several factors make preventive care less broadly effective at reducing health care spending than might be expected. For some preventive services, clinical evidence on effectiveness is lacking: In its 2006 review of such evidence, the U.S. Preventive Services Task Force was neutral toward—neither recommending nor discouraging the use of—approximately 40 percent of the services it reviewed because of a lack of evidence. For other preventive services, clinical evidence shows benefits, but the cost of the intervention for the many people who might receive it would exceed the likely savings for the relative few who would avoid the disease as a result. In addition, a decision by the federal government to subsidize preventive care might shift some costs to the government that would otherwise be borne by the private sector.

A related issue is the ability of the federal government to reduce its spending on health care by fostering healthier behavior and lifestyles. Reducing risk factors for chronic diseases that afflict older Americans can reduce the prevalence of those diseases and thereby the Medicare spending that goes to treat them. However, the overall budgetary effect also depends on the cost to the government of the policies that reduce risk, other health care costs that are incurred by people who live longer, and additional Social Security benefits that are paid to people who live longer. The relative magnitude of those effects varies for different diseases, and research on the topic is limited. One recent study that incorporated the interactions of different medical conditions and the cost of treating them—but did

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<sup>13</sup> Joshua T. Cohen and others, "Does Preventive Care Save Money? Health Economics and the Presidential Candidates," *New England Journal of Medicine*, vol. 358, no. 7 (February 14, 2008), pp. 661–663.

not address Social Security outlays or the cost of risk-reducing policies—found that controlling diabetes would increase medical costs and that controlling obesity would reduce costs substantially.<sup>14</sup> Unfortunately, the design and costs of effective programs to reduce obesity are very unclear.

As with prevention, the budgetary impact of greater use of primary care would depend on the combination of increases and decreases in spending occurred. One study of the relationship between Medicare spending and the composition of the workforce of physicians found that, with the total number of physicians held constant, states with more general practitioners had lower spending.<sup>15</sup> Achieving that outcome, however, involves reducing the number of specialists in line with increasing the number of primary care physicians, and the mechanism for accomplishing that change (for example, the appropriate adjustments in payment policies) is unclear. Savings would be less likely if the number of specialists remained the same while the number of primary care physicians increased.

### **Increase Cost Sharing by Patients**

Increasing the cost-sharing obligations that individuals face in government health programs and private insurance would strengthen the incentives for them to use medical care prudently. Research has shown that patients are responsive to the price they pay for many aspects of care.<sup>16</sup> To be sure, the rationale for insurance is to limit patients' out-of-pocket costs, so people with significant health problems or with low income and few assets could not pay a large share of their health costs themselves; cost sharing could be designed to maintain appropriate financial protection while still creating some sensitivity to cost. In addition, maintaining lower cost sharing for certain preventive services, medications to treat chronic conditions, and other care that would reduce future spending (which falls under the rubric of "value-based insurance design") may make sense. Still, ensuring that patients have some financial stake in decisions about treatment methods would lead them to ask their doctors more questions about the effectiveness of different tests and treatments and to make better-informed and more cost-sensitive decisions about their care.

CBO's *Budget Options* volume includes a number of approaches to modifying cost sharing in the Medicare program. One option to increase cost-sharing liabilities for most patients but place an upper cap on a patient's total annual liability was estimated to save \$26 billion over 10 years. Making those changes and simultaneously restricting the amount of cost sharing that could be covered by

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<sup>14</sup> Dana P. Goldman and others, "The Value of Elderly Disease Prevention," *Forum for Health Economics & Policy*, vol. 9, no. 2 (2006).

<sup>15</sup> Katherine Baicker and Amitabh Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs*, Web Exclusive (April 7, 2004), pp. W184–W197.

<sup>16</sup> See Joseph P. Newhouse and the Insurance Experiment Group, *Free for All: Lessons from the RAND Health Insurance Experiment* (Cambridge, Mass.: Harvard University Press, 1993); and Congressional Budget Office, *Key Issues*, pp. 73–74.

individually purchased supplemental (medigap) insurance nearly tripled the estimated amount of budgetary savings. In addition, changing the tax treatment of employment-based health insurance (discussed next) would encourage a higher degree of cost sharing in private insurance, along with other effects.

### **Modify the Tax Treatment of Employment-Based Health Insurance**

Nearly all analysts agree that the current tax treatment of employment-based health insurance—which exempts most payments for such insurance from both income and payroll taxes—dampens incentives for cost control because it is open-ended. Those incentives could be changed by restructuring the tax exclusion to encourage workers to join health plans with lower premiums; those lower premiums would arise through a combination of higher cost-sharing requirements and tighter management of benefits.

CBO's *Budget Options* volume discusses a number of such changes. One option would replace the current tax exclusion with a refundable but more limited tax credit. Another option would limit the amount of health insurance premiums that could be excluded from income and payroll taxes to specific dollar amounts that represented the 75th percentile of premiums paid by or through employers.<sup>17</sup> These approaches would change workers' incentives about how much insurance to purchase and how much care to demand, and they would increase federal revenues by several hundred billion dollars over 10 years.

### **Imposing Ongoing Pressure to Increase Efficiency in the Health Care System**

Vigorous implementation of specific reforms discussed in the preceding section could save money for the federal government in the medium term; they could also lay the groundwork for long-term savings. However, many of the reforms would only reach fruition with substantial changes in how medicine is practiced. Therefore, the largest savings would be reaped slowly, as experts learn more from experience with innovative approaches to financing and delivering care and as payment rules are adjusted to shift behavior further and capture savings for the federal government.

To ensure that *current* legislation puts the federal budget on a more sustainable path will probably require creating a framework for federal health care spending that imposes ongoing pressure to increase efficiency over time—particularly but not exclusively in the case of providers. Such pressure could be imposed in several ways, including reducing Medicare's payment updates automatically to take account of expected productivity gains; reducing Medicare payments in higher-spending areas of the country; giving the Secretary of Health and Human Services broad discretion to change Medicare to produce savings, but imposing an

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<sup>17</sup> The dollar amounts in 2010 would be about \$17,300 a year for family coverage and about \$6,800 a year for individual coverage.

across-the-board reduction in payments to providers if savings are not achieved in other ways; and limiting the growth of Medicare’s implicit subsidy of premiums.

Yet for any of those approaches to work over time, the Congress would need to let the legislated changes to payments take effect—even in the face of concerns from providers and patients. If, instead, the Congress ended up relieving the pressure by boosting payments, then the anticipated savings would prove to be illusory. The repeated deferral of the cutbacks in payments to physicians called for by Medicare’s sustainable growth rate mechanism is a cautionary example.

### **Reduce Annual Updates in Medicare’s Payments to Reflect Expected Productivity Gains**

Under current law, Medicare’s fee-for-service payments to caregivers in a variety of facilities (including acute care and long-term care hospitals, outpatient facilities, skilled nursing facilities, and home health agencies) are determined according to preset fee schedules. The basic payment rates are updated annually to reflect changes in the prices of various inputs (such as labor and equipment) that are used to provide medical services. Those prices are measured by market-basket indexes, which combine various price increases into a single update factor for each type of provider. Each index is designed to approximate the changes in costs that providers incur as a result of changes in input prices—under an assumption that the quantity, quality, and mix of those inputs remain constant. To the extent that providers increase their productivity over time—for example, by using fewer inputs or a less expensive mix of inputs to produce the same or greater output—the payment updates overstate the actual increases in costs. Indeed, the Medicare Payment Advisory Commission (MedPAC) often recommends that updates be set equal to changes in market-basket indexes less overall productivity growth in the economy (as long as access to care and other measures meet appropriate standards).

Some experts maintain that increased use of information technology and a new focus on efficiency will yield substantial productivity gains in the health sector.<sup>18</sup> Some of those gains may appear as reductions in the quantity of services and thus yield savings automatically for the government. However, most of the gains are likely to take the form of reduced costs per service, which would cut government spending only if the government cut the prices it pays (and otherwise would end up boosting providers’ profit margins).<sup>19</sup> Imposing slower growth in payments would create ongoing pressure on providers to identify and adopt efficiencies; it would also, however, create risks for providers and patients if the efficiency gains were not achieved.

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<sup>18</sup> See, for example, David Cutler, “Health System Modernization Will Reduce the Deficit,” (May 11, 2009), available at [www.americanprogressaction.org/issues/2009/05/pdf/health\\_modernization.pdf](http://www.americanprogressaction.org/issues/2009/05/pdf/health_modernization.pdf).

<sup>19</sup> For an illustration of that approach, see Option 54 in CBO’s December 2008 *Budget Options* volume.



More generally, reducing payment updates in the fee-for-service Medicare system could also prove to be a powerful mechanism for shifting providers into new payment schemes and organizational arrangements. Anticipated large reductions in payments to physicians under the sustainable growth rate mechanism, for example, could provide an impetus to physicians to join accountable care organizations, where they might receive bonuses for low-cost high-quality care. However, the fact that the Congress has intervened to prevent past cuts in payment rates that the mechanism would have caused makes it less likely that physicians will believe that scheduled future reductions will actually occur.

### **Reduce Medicare Payments in Higher-Spending Areas**

Another tack for applying ongoing pressure to restrain spending would be to reduce Medicare payments, or the growth in those payments, in higher-spending areas of the country. CBO recently examined several variants of this approach in its *Budget Options* volume: reducing Medicare fees for physicians in high-spending areas, reducing Medicare payments across the board in high-spending areas, reducing Medicare's payments to hospitals in areas with a high volume of elective admissions, and imposing a surcharge on cost sharing by Medicare beneficiaries in high-spending areas.

This approach would focus directly on reducing the geographical disparities that currently exist in health care spending, although it would not target specific medical providers or types of services that might be most responsible for the differences in spending. As with reductions in payment updates, this approach would create risks for providers and patients in higher-spending areas if the efficiency gains were not achieved. The overall challenge in reducing the use of care that seems to be wasteful is trying to distinguish that care from necessary care, and that task is made only somewhat easier by focusing attention on geographic areas where wasteful spending is more likely to be occurring.

### **Combine Increased Discretion to Change Medicare With a Fallback If Savings Were Not Obtained**

Another way to ensure significant savings in Medicare would be to give the Secretary of Health and Human Services, the Administrator of the Centers for Medicare and Medicaid Services, or some governmental entity broad discretion to make changes in Medicare to produce savings—but also to impose an across-the-board reduction in payments to providers if sufficient savings were not achieved in other ways.<sup>20</sup>

Many experts think that broader discretion for the administrators of Medicare would help to encourage innovation and enhance efficiency in any event. However, the fallback reductions in payments to providers would be crucial in

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<sup>20</sup> For an illustration of that approach, see Option 114 in CBO's December 2008 *Budget Options* volume.

encouraging providers to accept other changes in the program instead. Moreover, as noted above, this mechanism and others in this section would only be effective in the end if the Congress let the legislated reductions in payments take effect.

**Limit the Growth of Medicare’s Subsidy of Premiums**

One other mechanism for imposing ongoing pressure to achieve efficiencies in Medicare would be to limit the growth of the program’s implicit subsidy of premiums. If increases in medical costs beyond some threshold were borne at least partly by Medicare beneficiaries rather than the government, the government’s financial burden could be reduced. In addition, beneficiaries would then face strong incentives to make informed, cost-sensitive decisions about their medical care. Such changes could be designed to maintain greater protection for older beneficiaries or beneficiaries with lower income.