

Antos, Joseph

Working Paper

Slowing health spending growth and expanding coverage: A bipartisan solution

AEI Economics Working Paper, No. 2019-19

Provided in Cooperation with:

American Enterprise Institute (AEI), Washington, DC

Suggested Citation: Antos, Joseph (2019) : Slowing health spending growth and expanding coverage: A bipartisan solution, AEI Economics Working Paper, No. 2019-19, American Enterprise Institute (AEI), Washington, DC

This Version is available at:

<https://hdl.handle.net/10419/280608>

Standard-Nutzungsbedingungen:

Die Dokumente auf EconStor dürfen zu eigenen wissenschaftlichen Zwecken und zum Privatgebrauch gespeichert und kopiert werden.

Sie dürfen die Dokumente nicht für öffentliche oder kommerzielle Zwecke vervielfältigen, öffentlich ausstellen, öffentlich zugänglich machen, vertreiben oder anderweitig nutzen.

Sofern die Verfasser die Dokumente unter Open-Content-Lizenzen (insbesondere CC-Lizenzen) zur Verfügung gestellt haben sollten, gelten abweichend von diesen Nutzungsbedingungen die in der dort genannten Lizenz gewährten Nutzungsrechte.

Terms of use:

Documents in EconStor may be saved and copied for your personal and scholarly purposes.

You are not to copy documents for public or commercial purposes, to exhibit the documents publicly, to make them publicly available on the internet, or to distribute or otherwise use the documents in public.

If the documents have been made available under an Open Content Licence (especially Creative Commons Licences), you may exercise further usage rights as specified in the indicated licence.



Slowing health spending growth and expanding coverage: A bipartisan solution

Joseph Antos

*Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American
Enterprise Institute.*

AEI Economics Working Paper 2019 – 19
November 2019

Slowing Health Spending Growth and Expanding Coverage: A Bipartisan Solution

Joseph Antos, *Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute.*

A common theme leading up to the 2020 election is that the Affordable Care Act (ACA) should be repealed and replaced. The political extremes of the Republican and Democratic parties want to repeal the ACA, but for opposite reasons. Republicans believe the ACA went too far in expanding government control over private insurance markets. Democrats think the law did not go far enough. Starting over again, either through a Supreme Court decision in *Texas v. United States* that makes the ACA unconstitutional or through future legislation that replaces the ACA with Medicare for All or some variant of a single-payer system, is the common element supported by those furthest from the political center. Neither approach leads to a reformed system that could gather wide public support.

Whatever the motivation, ripping out the current system by the roots is not a formula for real reform of our health system. To achieve lasting bipartisan support, the next health reform should build on our mixed private/public insurance system and focus on specific policies that can help slow unnecessary growth in health spending, expand insurance coverage, and promote better health -- not just more insurance -- for all Americans.

Extreme Proposals Would Not Work

There is broad public agreement, regardless of one's political views, about the goals of health reform. Health insurance should be affordable and accessible for everyone, including those with pre-existing health conditions. Health care should also be affordable in terms of the out-of-pocket costs families pay net of insurance benefits. Low-income families should be given financial support for their health costs. The health system should be oriented to produce value over volume. Policies should promote efficiency, quality of care, and medical innovation.

These goals all require processes that spur improvement and resolve problems as progress is being made. The most important goals are works in progress rather than simple metrics that can be met with simple one-time solutions. Substantial reforms require significant changes in the business and practice of medicine. Although policy analysts often talk about needing to disrupt the system, the average American is not eager to have his or her own insurance and medical arrangements disrupted.

ACA repeal?

Republicans faced these issues in attempting to agree on an ACA replacement plan in 2017 that would reduce federal control over insurance markets, give states more flexibility in running their Medicaid programs, and promote greater consumer choice and responsibility. They developed numerous proposals to repeal, defund, or delay provisions of the ACA. Despite majorities in both houses of Congress, only the ACA's individual mandate was repealed as part of the Tax Cuts and Jobs Act.¹

A major reason for the lack of consensus among congressional Republicans was the impact of new reforms on popular ACA provisions, including pre-existing conditions protections and other policies that expanded insurance coverage. The Congressional Budget Office (CBO) predicted that Republican

proposals would reduce ACA protections for those with pre-existing conditions, significantly reduce funding to states for Medicaid, and increase the number of uninsured.²

The prospect that the courts might declare the ACA unconstitutional in *Texas v. United States* poses a painful, if unlikely, challenge for Republicans during the upcoming election campaign.³ Public support for major ACA insurance provisions such as the exchanges, insurance subsidies, and the Medicaid expansion remains strong.⁴ Health costs are a top issue for voters, regardless of party, and significant disruption would raise fears that insurance might become less available and more expensive.⁵

Medicare for All?

Leading Democrats seeking their party's presidential nomination have adopted their own versions of repeal and replace in the hope of winning primaries that largely attract voters with more extreme policy views than average. Sen. Bernie Sanders' Medicare for All (M4A) plan would eliminate private health insurance, Medicaid, and other coverage -- including, ironically, Medicare. Americans would be required to enroll in a government plan with far broader benefits than any insurance available today with no premiums or cost-sharing.⁶ Despite the \$32 trillion 10-year price tag and no clear plan on raising the money to implement M4A, the bill was cosponsored by other contenders for the nomination, including Senators Elizabeth Warren, Kamala Harris, and Cory Booker.⁷

M4A is a thinly-disguised government price-setting scheme. Supporters correctly point out that U.S. prices for health services are far higher than in other developed countries.⁸ They hope that full government price controls would lower the cost of health care without reducing access to care or medical innovation.

That overlooks the dominance of politics over pricing formulas. Medicare's Sustainable Growth Rate (SGR) is a case in point. Under the SGR, excessive growth in Medicare physician payments was supposed to trigger across-the-board reductions.⁹ That occurred once, in 2002—the first year that the SGR was to take effect—with a reduction of 4.8 percent. After that, Congress over-rode the SGR formula until 2015 when, in the face of a 21.2 percent payment reduction, the SGR was repealed. One could expect a similar pattern with M4A: initial price restraint, followed by legislated increases in response to industry and patient complaints.

That leaves M4A with two unpalatable outcomes. Either price controls work, which threatens to disrupt access to care, or they do not work, which means that health spending continues to rise at economically unsustainable rates. In either case, hundreds of millions of Americans would be forced to give up coverage they know for promises that might not be kept.

Public option?

A seemingly more moderate alternative to M4A is a public option available as an alternative to private insurance. Opinion polls strongly indicate that Americans like the idea of having access to a federal plan without being forced to drop their current coverage.¹⁰ But a public option cannot succeed without adopting policies that reduce cost to consumers while maintaining a broad provider network. Such policies eventually would put private insurers out of business.

The Medicare Exchange Health Plan (or Medicare-X) proposed by Senator Michael Bennet has the key features of a public option plan that could gain political traction during an election year.^{11,12} Federally-

approved Medicare-X plans would be offered as an additional insurance option alongside private insurers through Affordable Care Act (ACA) exchanges.

To keep costs down, Medicare-X would pay providers at Medicare rates, which are 30 to 60 percent lower than commercial rates paid by private insurers on the exchanges.¹³ To ensure a broad network, the government would require all health care providers who have either Medicare or Medicaid patients to accept Medicare-X enrollees, with the penalty being loss of their entire Medicare and Medicaid business.

Consequently, Medicare-X plans would be able to offer lower premiums and broader provider networks than their private competitors — but only because the government put its thumb on the scales. Private insurers could try to match the public option's premiums by lowering their payment rates, but hospitals and doctors could reject those terms. Private insurers who cut payments too low would be left with provider networks inadequate to meet the needs of patients.

Medicare-X would quickly drive private plans out of the exchanges. Once established, advocates would open the program to more consumers. Employer coverage would be vulnerable too. In time, the public option would crowd out the space available for private insurance and make hospitals and doctors dependent on payments controlled by the federal government. Tight eligibility limits on the public option would delay this breakdown, but only if policymakers resist the temptation to expand the program.

M4A or a public option would achieve universal or near-universal coverage. But that would not guarantee access to necessary services or one's provider of choice. Sharply lower payments would drive some providers out of medicine and discourage others from making the investment necessary to become a physician or build a medical facility. Cost growth would slow, but access, quality, and innovation would suffer.

Building on What Works

A bipartisan strategy to slow health spending growth, increase insurance coverage, and promote value over volume in health care builds on our existing health care system with its mix of private and public financing, markets, and regulation. Rather than one grand plan, this calls for a series of policies aimed at correcting specific problems in the way health care is financed and delivered. Real reform is an ongoing process, and it is more likely to be successful if solutions are developed in local markets rather than dictated from Washington.

Such a strategy would rely on four main tools.¹⁴

1. **Information:** Greatly improving information about prices and outcomes to spur cost-reducing pressure from patients and help consumers, providers, and insurers make more cost-effective choices.
2. **Bundled payments:** Shifting away from fee-for-service payment where possible, holding organized provider groups responsible for the cost and quality of the treatment provided to patients.

3. **Competition:** Removing barriers to competition among insurers and health care providers, using the power of competitive markets to drive toward cost-effective health care delivery.
4. **Targeted regulation:** Appropriate regulation and direct intervention where markets are demonstrably not workable.

Within that framework, what problem could Republicans and Democrats agree to address through federal legislation? Surprise billing, state proposals to tie Medicaid expansion to work requirements, price transparency, and other issues that have received attention from legislators on both sides of the aisle are the most likely possibilities.

Example: Revising Medicare Part D

We focus on a long-needed reform of Medicare Part D prescription drug benefit that would have a major impact on what seniors pay for their prescriptions.¹⁵ Moreover, correcting a major defect in this government program would reduce price distortions that affect all purchasers in the private market.

Part D operates through competing private plans. In principle, the plans have strong incentives to negotiate low prices for the drugs on their formularies. However, flaws in Part D's design blunt that incentive, increase program spending, and expose beneficiaries to the risk of high out-of-pocket costs.

Under the 2019 standard benefit structure, Part D enrollees are responsible for a \$415 deductible, 25 percent coinsurance for covered drug expenses up to \$3,820, and 5 percent of costs above a \$5,100 catastrophic limit.¹⁶ Medicare provides a per-enrollee direct subsidy to Part D plans based on the national average of plan bids. This is a prospective subsidy—similar to a capitation payment—putting the plans at risk for managing costs below the catastrophic threshold.

The program also subsidizes 80 percent of covered drug spending above the catastrophic threshold through individual reinsurance, with Part D plans paying 15 percent and enrollees paying the remaining five percent with no cap on their out-of-pocket costs. This approach was adopted to avoid having Part D plans design their formularies and benefits to avoid enrolling individuals with exceptionally high expense, but it reduces the incentive for plans to manage costs above the threshold since much of their potential liability is shifted to the taxpayer.

It has also led to a dramatic shift in the way prescription drugs are priced. Instead of negotiating for a low up-front price, plans have an incentive to negotiate higher list prices and receive rebates from manufacturers. With higher list prices, more beneficiaries are exceeding the catastrophic spending level and federal payments for reinsurance have ballooned. Between 2007 and 2016, reinsurance payments increase from \$8 billion to \$35 billion while the direct subsidy dropped slightly from \$18 billion to \$16 billion.¹⁷

This shift to higher list prices and larger rebates has had an impact on the entire pharmaceutical market. Since insurers typically base the amount enrollees pay in coinsurance on list prices, consumers outside the Medicare program are also seeing their out-of-pocket payments increase sharply.

Congress has advanced several proposals to lower prescription drug costs, including proposals to redesign the Part D benefit.¹⁸ They have several features in common, including placing a true

catastrophic cap on the maximum out-of-pocket costs that a senior could pay and a shift in costs above that cap from Medicare to drug manufacturers and Part D plans.

While there is wide agreement about the general problem, more time is needed to settle on the details of a reform that can be tolerated by the major actors, including the pharmaceutical industry. Such a deal can be struck, but not in the heat of a presidential election.

¹ Timothy Jost. “The Tax Bill And The Individual Mandate: What Happened, And What Does It Mean?” Health Affairs. December 20, 2017. <https://www.healthaffairs.org/doi/10.1377/hblog20171220.323429/full/>.

² CBO. “H.R. 1628, American Health Care Act of 2017, Cost Estimate.” May 21, 2017.

<https://www.cbo.gov/publication/52752>; CBO. “H.R. 1628, Better Care Reconciliation Act of 2017, Cost Estimate.” June 26, 2017. <https://www.cbo.gov/publication/52849>.

³ Li Zhou. “The latest legal challenge to the Affordable Care Act, explained.” July 10, 2019.

<https://www.vox.com/policy-and-politics/2019/7/9/20686224/affordable-care-act-constitutional-lawsuit-fifth-circuit-court-texas-district-court>.

⁴ Kaiser Family Foundation. “Potential Impact of Texas v. U.S. Decision on Key Provisions of the Affordable Care Act.” March 26, 2019. <https://www.kff.org/health-reform/fact-sheet/potential-impact-of-texas-v-u-s-decision-on-key-provisions-of-the-affordable-care-act/>.

⁵ Ashley Kirzinger, Bryan Wu, Cailey Muñana, and Mollyann Brodie. “Kaiser Health Tracking Poll – Late Summer 2018: The Election, Pre-Existing Conditions, and Surprises on Medical Bills.” September 5, 2018.

<https://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-late-summer-2018-the-election-pre-existing-conditions-and-surprises-on-medical-bills/>.

⁶ Congress.gov. “S.1129 - Medicare for All Act of 2019.” April 10, 2019. <https://www.congress.gov/bill/116th-congress/senate-bill/1129>.

⁷ Charles Blahous. “The Costs of a National Single-Payer Healthcare System.” Mercatus Center. July 30, 2018.

<https://www.mercatus.org/publications/government-spending/costs-national-single-payer-healthcare-system>; Congress.gov. “S.1129 - Medicare for All Act of 2019.” April 10, 2019. <https://www.congress.gov/bill/116th-congress/senate-bill/1129>.

⁸ Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan. “It’s The Prices, Stupid: Why The United States Is So Different From Other Countries.” Health Affairs. May/June 2003.

<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.22.3.89>.

⁹ Keith Fontenot, Caitlin Brandt, and Mark B. McClellan. “A primer on Medicare physician payment reform and the SGR.” Brookings Institution. February 2, 2015. <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2015/02/02/a-primer-on-medicare-physician-payment-reform-and-the-sgr/>.

¹⁰ Kaiser Family Foundation. “Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage.” September 12, 2019. <https://www.kff.org/slideshow/public-opinion-on-single-payer-national-health-plans-and-expanding-access-to-medicare-coverage/>.

¹¹ Jessie Hellmann. “Democratic senators unveil ‘Medicare X’ bill to expand coverage.” The Hill. April 2, 2019.

<https://thehill.com/policy/healthcare/436936-bennet-kaine-unveil-bill-to-expand-medicare>.

¹² Joseph Antos and James C. Capretta. “The Heavy Hand of the Public Option.” RealClear Policy.

https://www.realclearpolicy.com/articles/2019/06/18/the_heavy_hand_of_the_public_option_111222.html.

¹³ John D. Shatto and M. Kent Clemens. “Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers.” Centers for Medicare and Medicaid Services. April 22, 2019.

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2019TRAlternativeScenario.pdf>.

¹⁴ Joseph Antos and Alice Rivlin. “A New Vision for Health Reform.” AEI and Brookings Institution. September 2019.

<https://www.aei.org/research-products/report/a-new-vision-for-health-reform/>.

¹⁵ Joseph Antos. "The Cost of Rising Prescription Drug Prices." Statement before the House Committee on Ways and Means. February 12, 2019. <https://www.aei.org/research-products/testimony/testimony-the-cost-of-rising-prescription-drug-prices/>.

¹⁶ Medicare Payment Advisory Commission. "Part D Payment System." October 2019.

http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_partd_final_sec.pdf.

¹⁷ Medicare Payment Advisory Commission. "March 2018 Report to the Congress: Medicare Payment Policy." March 15, 2018. http://medpac.gov/docs/default-source/reports/mar18_medpac_ch14_sec.pdf.

¹⁸ Tara O'Neill Hayes. "Competing Proposals to Reform Medicare Part D." American Action Forum. September 23, 2019. <https://www.americanactionforum.org/insight/competing-proposals-to-reform-medicare-part-d/>.