

Deficit Reduction Alternatives in Healthcare

Summary of the Issue

Measures to curb federal spending by trimming Medicare and Medicaid payments are options in the current deficit reduction environment. Providers already face billions of dollars in Medicare and Medicaid payment cuts. Efforts to further cut Medicare and Medicaid payments to providers jeopardize access to high quality healthcare services for America's seniors and the poor. True entitlement reform and approaches to change the healthcare delivery system are needed – not provider cuts.

As Congressional leaders and the Administration have debated deficit reduction, several “plans” and proposals have emerged. These include:

- President Obama's budget proposals in February and May
- House Budget Chairman Paul Ryan's budget proposal
- The Congressional Budget Office's report on options for reducing the Federal deficit
- The National Commission on Fiscal Responsibility and Reform (Simpson-Bowles)
- The Debt Reduction Task Force (Rivlin-Domenici)
- The “Gang of 6” US senators that developed a bi-partisan plan to reduce the deficit
- House Majority Leader Eric Cantor's list of spending reductions

These various plans proposed many types of deficit reduction provisions including across-the-board reductions or sequestration, formulaic and deadline-based “triggers” of budgetary action, and specific policy alternatives. Among these options, there are many healthcare policy alternatives that could be used to support deficit reduction that don't simply cut Medicare and Medicaid payments. The following alternatives should be discussed and thoughtfully considered in the deficit reduction debate:

- Modernizing cost sharing for Medicare, Medicaid and TRICARE
- Increasing the eligibility age for Medicare
- Increasing the FICA tax to support Medicare Part A spending
- Implementing “real” comparative effectiveness research and programs
- Improving programs to improve care at the end of life
- Developing programs to coordinate care for individuals eligible for both Medicare and Medicaid
- Applying Medicare reforms in the ACA (such as accountable care organizations, medical homes, bundling) to Medicaid
- Increasing use of generic drugs and biologicals
- Modernizing the Medicaid long term care benefit
- Medical liability reform
- Taxing Cadillac health plans
- Taxing junk foods and sugary drinks

These types of reforms can be used to reduce spending, improve quality, better coordinate care, enhance personal responsibility, and modernize Medicare, Medicaid and the entire healthcare system.

See table on reverse

Healthcare Alternatives for Deficit Reduction

The following table provides more detail describing healthcare alternatives that were included in one or more of the various deficit reduction proposals and should be considered for deficit reduction.

Option	Description	Plans that include option	10-Year Savings
Medical Liability Reform	<p>Three of the plans included caps on non-economic and punitive damages. The most developed proposal in the CBO Options document would impose certain nationwide curbs on medical malpractice torts, capping non-economic damages to \$250,000; punitive damages at \$500,000 or two times the value awards for economic damages (whichever is greater); impose a "fair-share" rule (replacing joint-and-several liability); impose a statute of limitations for one year from the date of injury discover for adults; 3 years for children.</p> <p>Modify collateral source rule; impose a statute of limitations; replace joint-and-several liability with a fair-share rule; and create specialized "health courts," allow safe havens for providers who follow best practices.</p>	<p>CBO Options Ryan Budget Rivlin-Domenici</p> <p>Simpson-Bowles</p>	<p>\$62.4 Billion (CBO proposal)</p> <p>\$17 Billion</p>
Reduce Medicare Costs by Changing Cost-Sharing Structures for Medicare Part A and B	<p>Establish a single combined annual deductible for Part A and B, along with a 20 percent coinsurance for spending above deductible up to a certain amount.</p> <p>Increase the basic premium for Medicare Part B from 25% to 35% of the Program's cost. When Part B began in 1966, the premium was intended to finance 50% of the Part B costs per enrollee.</p> <p>Prohibit Medigap plans from covering the first \$550 of an enrollee's cost-sharing liabilities and limit coverage to 50 percent of the next \$5000 in Medicare cost-sharing.</p> <p>Impose a co-payment for each of the first 20 days of care in a SNF equal to 5 percent of the inpatient deductible (approx. \$59 per day in 2013) with a maximum co-payment equal to the inpatient deductible.</p> <p>Require a 10% co-pay for each episode of home health services.</p> <p>Make laboratory services subject to the Part B standard deductible and to coinsurance requirements.</p>	<p>Simpson-Bowles CBO Options</p> <p>CBO Options Rivlin-Domenici</p> <p>Simpson-Bowles CBO Options Cantor List</p> <p>CBO Options Cantor List</p> <p>CBO Options Cantor List</p> <p>CBO Options</p>	<p>\$32.2 Billion</p> <p>\$241.2 Billion</p> <p>Up to \$53 Billion</p> <p>\$21.3 Billion</p> <p>\$40.1 Billion</p> <p>\$23.8 Billion</p>
Raise the age of eligibility for Medicare to 67	<p>Raise the age of eligibility for Medicare by 2 months every year beginning with people who were born in 1949 until the eligibility age reached 67.</p>	<p>Ryan Budget CBO Options</p>	<p>\$124.8 Billion</p>
Pharmaceutical Pricing	<p>Require manufacturers of brand-name drugs to pay the federal government a rebate on drugs purchased by enrollees in the low-income subsidy program. The program would reflect the current rebate system for Medicaid.</p> <p>Speed up availability of generic biologics, and prohibit brand-name companies from entering into a "pay for delay" agreements with generic companies. Implement Medicaid management of high prescribers and users of prescription drugs.</p> <p>Use Medicare's buying power to increase rebates from pharmaceutical companies.</p>	<p>CBO Options Obama Budget Simpson-Bowles</p> <p>Obama Budget</p> <p>Obama Budget Rivlin-Domenici</p>	<p>\$112.0 Billion</p>

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Slow the Growth of Federal Contributions for the Federal Employees Health Benefits Program (FEHBP)	Limit the federal government's contribution to \$5,000 towards the cost of an individual premium or \$11,000 for a family premium beginning on 1/1/13. The federal contribution would then increase annually at the rate of inflation as measured by the CPI for all urban consumers, rather than at the average weighted rate of change in FEHBP premiums. Simpson-Bowles plan would include a similar pilot program for FEHBP.	CBO Options Simpson-Bowles Cantor List	\$31.5 Billion in Mandatory Spending; \$41.9 Billion in discretionary spending
Health care related revenues	<p>Standardize the base on which the federal excise tax on alcohol is levied by using the proof gallon as the measure for all alcoholic beverages.</p> <p>Replace the 0.9 percent surtax on high-income taxpayers with a 1.0 percentage point increase in the total HI tax on all earnings. The HI tax rate for both employers and employees would increase by 0.5 percentage points to 1.95 percent, resulting in a combined rate of 3.9 percent.</p> <p>Impose a federal excise tax of 3 cents per 12 ounces of "sugar-sweetened" beverage.</p> <p>Impose the excise tax on employment-based health care coverage above certain limits beginning in 2014 instead of in 2018.</p>	<p>CBO Options</p> <p>CBO Options</p> <p>CBO Options Rivlin/ Domenici</p> <p>CBO Options</p>	<p>\$59.9 Billion</p> <p>\$650.8 Billion</p> <p>\$50.4 Billion</p> <p>\$310 Billion</p>
Introduce Cost Sharing Responsibility for TRICARE Beneficiaries	<p>Introduce minimum out-of-pocket requirements for "TRICARE For Life" (TFL) beneficiaries also covered by Medicare. As proposed, TFL would not cover any of the first \$550 of an enrollee's cost sharing payments under Medicare and would cover only 50 percent of the next \$4,950 in such payments.</p> <p>Raise enrollment fees, copayments and deductibles for younger military retirees – those younger than 65 – who enroll in TRICARE. TRICARE coverage was originally considered a supplement or safety net for military retirees, not as a replacement for benefits offered by post-service civilian employers.</p>	<p>CBO Options</p> <p>CBO Options</p>	<p>\$43 Billion</p> <p>\$28.1 Billion</p>
Base Social Security COLAs and other entitlements on the chained CPI-U	Some policymakers have discussed changing the measure of inflation for Social Security COLAs (CPI-W) and other entitlement program COLAs currently based on CPI-U to the "chained" CPI-U. Social security COLAs are currently based on the CPI-W (consumer price index for urban wage earners and clerical workers). The chained CPI-U (C-CPI-U) is an alternative measure of inflation (also calculated by the Bureau of Labor Statistics) that more fully incorporates the effects of changes in patterns of spending and which most economists and analysts believe more accurately reflects the actual increase in the cost of living.	CBO options (Social Security only)	<p>\$112 Billion (Social Security only)</p> <p>Effect on other entitlements unknown</p>
Place "dual eligibles" in Medicaid managed care	Give Medicaid full responsibility for providing health coverage to dual eligibles and requiring that they be enrolled in Medicaid managed care programs. Medicare would continue to pay its share of the costs, reimbursing Medicaid.	<p>Simpson-Bowles</p> <p>Cantor List</p> <p>Rivlin/Domenici</p>	<p>\$12 Billion</p> <p>\$0-5 Billion ("Savings dependent on scoring")</p> <p>\$5 Billion</p>