

Fiscal Priorities in the 114th Congress: Restoring Balance to Federal Health Spending

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Chairman Pitts, Ranking Member Pallone and members of the Subcommittee, thank you for the opportunity to testify regarding fiscal priorities in the 114th Congress. As a major driver of federal spending, our health care system must be central to this discussion. I would like to make three main points today regarding the fiscal future of the health care system in the 114th Congress.

- First, the expansive spending created by the Affordable Care Act (ACA) will continue to generate fiscal issues for years to come. The ACA was left largely untouched by the Budget Control Act, resulting in unrestrained spending in some of health care's most expensive programs. Next year Congress should rein in this spending and subject the ACA and Medicaid to cost saving reforms.
- Second, making reforms within the exchanges and cutting back on ACA spending will create savings; some of which should be utilized to ensure a sustainable Medicare program for seniors well into the future. In order to preserve Medicare for the next generation, big policy changes must occur, and savings generated through scaling back the excesses of health reform can help pay the way.
- Finally, decreasing ACA spending and applying some of these savings to Medicare reform is just part of the fiscal priorities conversation. Any change undertaken should lay a foundation for a more efficient health care system, and the 114th Congress should work to towards that ultimate objective by focusing on achievable goals in the present.

Reining in ACA Spending

ACA exchange subsidy related spending alone is estimated to cost over one trillion from 2015-2024.¹ Spending on subsidized insurance through the health insurance exchanges, excessively high Medicaid matching funds for the expansion population and other provisions in the ACA will continue to exacerbate our fiscal woes in future years. Congress should prioritize reasonable reductions in the funding for health insurance programs that are currently unsustainable. The American Action Forum (AAF) has examined a few policy options for more targeted spending that will also generate some savings.

Reworking Premium Assistance

Much of the ACA's spending comes from the premium assistance (subsidies) offered through the health insurance exchanges. As a major facet of the legislation, the health insurance exchanges completely remade the individual health insurance market. The Congressional Budget Office (CBO) estimates that \$17 billion will be spent in 2014 distributing subsidy dollars; and this spending will only continue to grow. CBO estimates that enrollment will grow to 13 million in 2015, 24 million in 2016 and reach up to 25 million by 2024, costing the federal government \$1.032 trillion over the next decade.

In general, subsidies are available to individuals and families between 100 percent and 400 percent of the federal poverty level (FPL).² This income range allows for a family of four making as little as \$23,850 a year (at 100 FPL) or as much as \$95,400 a year (400 percent of

FPL) to receive assistance with their monthly premium. Meanwhile the median family income in the United States was \$65,587 in 2013.³ These subsidy dollars should be targeted, and limited to, those who really need them. The income eligibility level for receiving subsidies can be decreased, while still providing for those families truly in need of assistance. Higher income families would still have the option of exchange plan coverage, but not at the taxpayers' expense.

A more targeted subsidy eligibility range would generate significant savings. AAF estimates⁴ that a decrease in subsidy eligibility levels could decrease federal spending by as much as \$181 billion from 2015-2023.⁵ The following chart demonstrates the savings associated with various decreases in subsidy income eligibility levels:

Table 1: Shifting Subsidy Eligibility Levels and Resulting Decrease in Federal Budget Deficit 2015-2023

Federal Poverty Level for Exchange Subsidy Eligibility	Reduction in the Federal Budget Deficit
400 percent FPL	\$0
375 percent FPL	\$43 billion
350 percent FPL	\$88 billion
300 percent FPL	\$181 billion

Increasing the Applicable Income Percentage in Exchanges

Another area where potential savings exist is within the applicable percentage of an individual's income used to determine the contribution to an insurance premium. Currently for individuals making between 100-400 percent FPL, the percentage of their income that is required to go toward purchasing health insurance is on a sliding scale, with individuals earning an income at 100 percent FPL required to contribute 2 percent of their income toward health insurance premiums and those making 400 percent of FPL required to contribute 9.5 percent of their income.⁶

If this sliding scale were shifted to require some individuals to contribute more to their monthly insurance premiums, the federal deficit could decrease by \$110 billion from 2015-2023. Shifting the scale upward for individuals making 200-400 percent FPL would generate savings while avoiding increases in cost for low income families in the 100-200 percent FPL range.

In AAF estimates, the applicable income percentage for households that earn between 200 percent and 400 percent of FPL would be moved from a range of 6.3 percent to 9.5 percent to a range of 6.3 percent to 12 percent. The increase would be incremental, raising the contribution for households that earn 250 percent FPL from 8.05 percent to 9 percent, those earning 300 percent of FPL from 9.5 percent to 10 percent, and those earning 400 percent of FPL from 9.5 percent to 12 percent. Though the changes to income contributions are small, the overall savings generated could make a significant dent in federal ACA spending in the exchanges.

Decreasing Medicaid Spending

The ACA allows for the expansion of the Medicaid program to higher income levels and provides historically high federal matching funds for those newly eligible for Medicaid under the expansion. Today, one in five individuals is covered under Medicaid, a number that will continue

to grow if more states opt to expand their Medicaid income eligibility levels as prescribed by the ACA. Medicaid spending is projected to reach \$570 billion by 2024 under the ACA, in part due to the large increase in the Federal Medical Assistance Percentage (FMAP) for expansion population Medicaid beneficiaries.⁷ The FMAP for the expansion population in 2014 was 100 percent, meaning that the federal government covered 100 percent of the cost of Medicaid beneficiaries made newly eligible under the ACA.

The expansion population FMAP should be a key point of review in the next Congress while looking for opportunities to decrease spending in the ACA. The expansion FMAP is set at an unreasonably high level—never falling below 90 percent—whereas the average FMAP for the legacy Medicaid program hovers around 57 percent.⁸ The high matching rate for this population is an incentive for states to prioritize the enrollment of higher income, newly eligible individuals at a lower cost to state budgets than other Medicaid beneficiaries. As a result, there is reasonable concern that states will cover higher income individuals while some of the most vulnerable, lowest income individuals remain on Medicaid waiting lists.

Medicaid expansion matching rates will decline from 100 percent to 95 percent in 2017, to 94 percent in 2018, 93 percent in 2019, and finally to 90 percent in 2020. However, a 90 percent federal share of Medicaid spending is still unsustainable in perpetuity, and a bifurcated FMAP based on income level is unnecessary and bureaucratic. While bringing the FMAP for expansion populations in line with states' traditional FMAP would make the most sense, even moderate reductions in the expansion FMAP will generate savings. If the scheduled decline is accelerated and the match is further decreased to 85 percent by 2020, federal Medicaid spending could be greatly decreased. Taking the FMAP rate from 100 percent to 95 percent in 2017, 90 percent in 2018, and finally to 85 percent in 2019, could reduce the federal budget deficit by \$23 billion from 2015-2023.⁹

Making the Exchanges More Competitive

One smaller change to the structure of certified plans in the exchange—known as qualified health plans (QHP)—would allow for plan issuers to design more products at more competitive prices. AAF estimates that providing the option of catastrophic coverage for all ages will result in savings for the federal budget.

In order to purchase a catastrophic plan, individuals must be under thirty years of age. These plans are only designed to provide coverage for high cost health care needs, and most other services must be paid out of pocket by the beneficiary.¹⁰ As a result, subsidies are not provided to individuals who purchase these plans and who would otherwise be eligible for subsidies based on their income. Eliminating age limits on individuals who wish to purchase a catastrophic plan would allow for a decrease in subsidy spending because additional individuals would move to the unsubsidized catastrophic plan if given the option. AAF estimates this small legislative change could result in savings of \$16 billion from 2015-2023.

Utilizing Savings to Preserve Medicare

In outlining fiscal priorities for the 114th Congress, the Medicare program should be placed at the top of the list along with ACA reforms. Medicare spending continues to climb, totaling \$3.4

trillion in projected federal spending between 2015 and 2019, and policymakers must come to an agreement on payment reforms for the program.¹¹

One answer to these continued issues could be changes to the ACA. The savings generated by cutting back on some of the ACA's spending provisions could be leveraged toward a sustainable, viable Medicare program for the next generation. The sustainable growth rate (SGR) must be remedied, and successful entitlement reforms such as Medicare Advantage and the prescription drug benefit known as Medicare Part D should be reinforced as mechanisms to preserve Medicare.

The Sustainable Growth Rate

In March of next year, Congress will again be forced to address SGR. Legislation must be passed that either ends SGR permanently or continues to avoid deep cuts to physician reimbursement.

In recent years, the SGR has been patched to avoid steep cuts.¹² The latest pieces of legislation passed avoided scheduled 24 percent cuts to provider reimbursements, and extended funding with a 0.5 percent increase in physician payment rates. The SGR was designed to control Medicare physician reimbursements, but has instead continued to stifle other federal entitlement reforms because it must constantly be addressed.

For the last decade the SGR cuts have been stopped or altered for fear of losing physician participation in Medicare. However, providing a permanent fix to the SGR comes at a cost. CBO estimates that permanently ending SGR would cost an estimated \$118.9 billion.¹³ While there is an ongoing debate about the degree to which a permanent SGR fix needs to be offset, the savings generated from the ACA policy changes laid out above could be put toward offsetting some of the cost of overhauling Medicare physician reimbursement policies.

Safeguarding MA and Part D

Along with the financing for SGR repeal, a fiscal priority of the next Congress should be preserving Medicare Advantage (MA) and Medicare Part D.

Medicare Part D is an example of a health care program that has benefited both the federal budget and beneficiaries. The program continues to come in under budget due to its competitive, market-based structure.¹⁴ Earlier this year, this successful benefit came under regulatory attack, threatening to completely undermine the success of the program.¹⁵ The proposed rule would have cost the program up to \$10 billion over the next ten years, placing a further burden on the federal budget for Medicare spending. Fortunately, the proposed rule was not finalized, but the risk for increased program costs and increased costs to beneficiaries remains if the administration again seeks to alter the program.

MA was the victim of large cuts under the ACA, in order to offset new spending on subsidy dollars for those enrolling in exchange coverage. As a private sector alternative to the expensive Medicare Fee for Service (FFS) model, MA plan reimbursement cuts will translate directly into decreased benefits for Medicare beneficiaries.¹⁶ According to AAF research, the ACA cuts to MA reimbursement combined with regulatory policy changes will result in an average of \$1,538 in lost benefits per MA enrollee in 2015 as compared to pre-ACA levels. It is entirely

appropriate for the next Congress to work to shore up this vital bridge to a post-FFS Medicare using savings derived from the ACA.

Setting Achievable Health Care Goals

Along with preserving key parts of the Medicare program and decreasing ACA spending, smaller goals can be accomplished as well. For example, pieces of the ACA that are unpopular on both sides of the aisle can be eliminated—such as the medical device tax and the independent payment advisory board (IPAB)—and health savings accounts (HSA) should play a larger role in exchange plans.

Most importantly, small, tangible accomplishments can serve as first steps in creating a more market driven health care system. The removal of the medical device tax will encourage innovative device makers to continue operations in the US, and the greater inclusion of HSAs in exchange plans will provide an incentive for consumers to pay closer attention to the health care services they utilize.

Coming to agreements on some provisions of health reform early will set the stage for a productive 114th Congress. It can also create a positive atmosphere for the more significant challenges to come; priorities such as SGR and—even further out—a social security disability insurance (SSDI) solution. In preparation for next year, health care spending will be a continued concern. In setting fiscal priorities for health care, Congress should start with small reforms to the ACA that have the potential for real savings.

¹ https://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf

² <http://americanactionforum.org/weekly-checkup/aca-subsidy-verification-minefield>

³ <https://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-249.pdf>

⁴ All American Action Forum cost estimates in this testimony were performed using a health insurance microsimulation model originally published by Stephen Parente: Parente, S.T., Feldman, R. “Micro-simulation of Private Health Insurance and Medicaid Take-up Following the U.S. Supreme Court Decision Upholding the Affordable Care Act.” Health Services Research. 2013 Apr; 48(2 Pt 2):826-49.

⁵ The Congressional Budget Office scored this policy option in November, 2013 and found that it would reduce the deficit by \$109 billion. The primary difference in the CBO estimate is a prediction that employer sponsored insurance enrollment will increase by about 4 million, leading to larger tax expenditures. (In fact, they estimate that savings from subsidies to \$182 billion over the same time period, which is offset by decreased revenues through the ESI tax exclusion.) Our model does not predict any meaningful change in ESI enrollment.

⁶ <http://aspe.hhs.gov/HEALTH/REPORTS/2014/PREMIUMS/2014MKTPLACEPREMBRF.PDF>

⁷ https://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf

⁸ <http://kff.org/health-reform/issue-brief/medicaid-financing-an-overview-of-the-federal/>

⁹ As estimated by the American Action Forum.

¹⁰ <https://www.healthcare.gov/choose-a-plan/catastrophic-plans/>

¹¹ https://www.cbo.gov/sites/default/files/45653-OutlookUpdate_2014_Aug.pdf. pg 12.

¹² <http://americanactionforum.org/research/primer-the-sustainable-growth-rate>

¹³ <https://www.cbo.gov/sites/default/files/cbofiles/attachments/49770-SGR-Menu.pdf>. Estimate based on freezing payment rates through 2024.

¹⁴ <http://americanactionforum.org/research/competition-and-the-medicare-part-d-program>

¹⁵ <http://americanactionforum.org/research/cms-rulemaking-and-medicare-part-d-stifling-innovation-limiting-access-and>

¹⁶ <http://americanactionforum.org/research/medicare-advantage-cuts-in-the-affordable-care-act-april-2014-update>