Deficit Reduction Alternatives in Health Care

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 health care services for America's seniors and the poor. True entitlement reform and approaches to change the health care 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
- 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 bipartisan 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 health care 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 any deficit reduction debate:

- Modernizing cost sharing for Medicare and Medicaid
- Increasing the eligibility age for Medicare
- Increasing the FICA tax to support Medicare Part A spending
- Implementing enhanced 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 health care system.

See table on reverse

Health Care Alternatives for Deficit Reduction

The following table provides more detail describing health care 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	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.	CBO Options Ryan Budget Rivlin-Domenici	$62.4 Billion (CBO proposal)
	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.	Simpson-Bowles	$17 Billion
Reduce Medicare Costs by Changing Cost-Sharing Structures for Medicare Part A and B	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.	Simpson-Bowles CBO Options	$32.2 Billion
	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.	CBO Options Rivlin-Domenici	$241.2 Billion
	Prohibit Medigap plans from covering the first $550 of an enrollee's cost-sharing liabilities and limit coverage to 50% of the next $5000 in Medicare cost-sharing.	Simpson-Bowles CBO Options Cantor List	Up to $53 Billion
Raise the Age of Eligibility for Medicare to 67	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.	Ryan Budget CBO Options	$124.8 Billion
Pharmaceutical Pricing	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.	CBO Options Obama Budget Simpson-Bowles	$112.0 Billion
	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.	Obama Budget	
	Use Medicare's buying power to increase rebates from pharmaceutical companies.	Obama Budget Rivlin-Domenici	
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	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.	CBO Options	$59.9 Billion
	Replace the 0.9% 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%, resulting in a combined rate of 3.9%.	CBO Options	$650.8 Billion
	Impose a federal excise tax of 3 cents per 12 ounces of "sugar-sweetened" beverage.	CBO Options Rivilin/ Domenici	$50.4 Billion
	Impose the excise tax on employment-based health care coverage above certain limits beginning in 2014 instead of in 2018.	CBO Options	$310 Billion
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)	$112 Billion (Social Security only) Effect on other entitlements unknown