

How Policymakers Use the National Health Accounts

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The views expressed in this paper represent the personal views of the author, and do not reflect the position of any organization with she is affiliated.

Several times a year, but particularly during the holiday season as the President's budget proposals are being finalized, the President's top health and economic policy advisors gather in the White House to consider health policy options. In these intense—and often tense—sessions, analysts are peppered with questions such as: “How fast is health care spending rising?, How does the rate of growth compare with previous years?, How do we compare to other industrialized countries?, Are we disadvantaged in the world economy because of escalating health spending?, What factors are driving health spending growth?, Is it mostly prescription drugs?, How much are beneficiaries paying? What is going on with Medicaid spending?, Is the distribution of costs between the public and the private sector changing?, Will health care spending EVER slow down or be brought under control?” pepper the analysts in the room.

Versions of the same scene are repeated around the Secretary's conference table at the Department of Health & Human Services, in the portrait-filled hearing rooms of the Ways & Means and Finance Committees on Capitol Hill, at the Medicare Payment Advisory Commission, and in think tanks around Washington throughout the year. Having been present at many such meetings, I can say with assurance that the worst moments occur when one does not have the information to answer the question. Whether they are Presidents, Senators, or Cabinet Secretaries, policymakers have a keen interest in data on national health spending trends in ordinary times. The passage of the Medicare Prescription Drug, Improvement and Modernization Act in 2003 (MMA) makes these far less than ordinary times. The MMA made sweeping changes in both Medicare and private health insurance, the effects of which are yet to be revealed. The National Health Accounts (NHA) will be among the first to tell the story, and undoubtedly the first to present a comprehensive picture of changing health care spending patterns. Already, there are many important questions waiting for answers. How many Medicare

beneficiaries will enroll in the new prescription drug benefit? How will the MMA affect the utilization and prices of prescription drugs? How many of the eligible low-income Medicare beneficiaries will sign up for the prescription drug subsidies? Will the increased payments to Medicare Advantage plans and new regional health plans have the desired effect of increasing private plan participation, particularly in rural and smaller urban areas? How many employers will take advantage of the subsidy for prescription drug coverage? How many employers will drop retiree health coverage? How many people will participate in health savings accounts? How much health spending will be shifted from the private sector to the public sector as a result of the MMA? And perhaps most important of all, how much will the new prescription drug benefit cost the Federal government over the next decade?

The NHA leadership team within the Centers for Medicare & Medicaid Services has developed several recommendations to account for the shifts in health spending in the MMA. Their recommendations conform to internationally accepted health accounting conventions, under which health spending is classified under mutually exclusive and exhaustive categories. This process ensures that all spending is counted in only one category, and that all health spending is accounted for, making it possible to both to calculate spending as a percentage of the gross domestic product (GDP) and to make accurate comparisons of one country's health spending against others.

The NHA report health care spending by source of funds and type of health care services. When this typology was developed in the early 1960s, classifying the source of funds was relatively straightforward. Most health care services were purchased directly out-of-pocket with limited private insurance, and there was no difficulty in identifying the source of payment as the entity that paid the bill. Over time, determining

the source of payment has grown more complicated. The health care market has become more complex, with Medicare and Medicaid entering into various kinds of contracts with health insurers and fiscal agents. In the private market, large businesses have increasingly become self-insured, and Congress has also passed laws mandating certain coverage or protections and altering the traditional spending patterns. As these changes occurred, the NHA team has tried to develop guidelines so that decisions are made to count all sources of payment, but only once.

Two examples illustrate the difficulties the NHA team has faced in developing these guidelines. Medicare contracts with private health plans to deliver services to beneficiaries. Should the source of payment be considered Medicare or private health insurance? On one hand, Medicare could be considered the payer because it sets the rules under which services are rendered and sends a payment to the plan on behalf of each beneficiary for each month during which they are enrolled. On the other hand, private health insurance could be considered the source of payment because private insurers actually make the payments to the hospitals, physicians, and other providers who serve the beneficiary. In this instance, the NHA team decided that Medicare should be considered as the source of payment, because it is the decision-maker and because beneficiaries are enrolled in private plans only through Medicare's auspices.

In the second example, State Medicaid programs transfer funds to Medicare for the Medicare Part B premium and Medicare coinsurance on behalf of dually eligible beneficiaries. Should the source of these payments be considered State Medicaid programs, because they actually make the payments, or Medicare, because the payments are for Medicare services? Because these payments could be counted only once, the NHA team decided to subtract these payments from Medicaid and attribute

them to Medicare, thus lowering Medicaid spending and raising Medicare spending. In part, they made the decision to attribute these payments to Medicare because they did not have the data necessary to allocate the specific amounts paid to Medicaid providers on behalf of dually eligible beneficiaries.

The MMA intensifies these classification questions because it reallocates so much spending among payers. The NHA team has made preliminary decisions about how to account for the following spending reallocations in the MMA:

- Spending for prescription drugs in Medicare Part D will be counted as Medicare expenditures;
- The maintenance of effort (“clawback”) payments made by states to Medicare for dually eligible beneficiaries, who will receive drug benefits through Medicare instead of Medicaid, will be counted as Medicare expenditures;
- Transitional assistance to Medicare beneficiaries in 2004 and 2005 for prescription drugs will be counted as a Medicare expenditure;
- Transitional payments to Medicare beneficiaries in 2004 and 2005 for private drug discount cards are to be counted as an administrative cost of private health insurance; and
- Employer subsidies paid by Medicare to private employers who provide qualifying retiree health benefits to Medicare eligible beneficiaries will be counted as private health insurance spending.

I have been asked to evaluate the NHA team’s preliminary decisions regarding these payment reallocations and to provide my perspective as a former policymaker and advisor to policymakers. I concur with the decisions to treat spending for prescription

drugs as Medicare expenditures, treating transitional cash assistance to Medicare beneficiaries for drug costs as Medicare expenditures, and treating transitional payments for the drug discount cards as private health insurance. However, I reach a different conclusion with respect to the NHA team's decisions to treat State "maintenance of effort" payments as Medicare expenditures and the employer subsidies as private health insurance spending. My concern stems in part from the continuing controversy over the costs of the Medicare prescription drug benefit. The debate over Medicare prescription drug coverage was one of the most fractious and partisan in the recent history of the Congress. During the Congressional debate, the cost of the benefit itself was the single most controversial issue. Some conservatives objected to expanding Medicare because of the cost of the benefit, and agreed to it only reluctantly, on the condition that the drug benefit cost no more than \$400 billion over ten years. Others objected on the grounds that the benefit was not comprehensive enough to meet the needs of many Medicare beneficiaries, and argued that higher spending was needed to provide an adequate benefit.

The controversy over costs has not abated since the MMA was enacted in 2003, with some calling for a reevaluation and rollback of the new prescription drug program, while others advocate providing the Secretary with increased authority to negotiate prescription drug prices to help control the costs of the program. The depth of the controversy over projected spending on the new drug benefit, coupled with already rising Medicare spending, means that the national health spending reports will be subject to much greater scrutiny than they have been in the past. I believe that policymakers will want to know as much as possible about spending for prescription drugs under the new benefit, and that they will request data with much more granularity than has been available in the past—e.g., by age group, income level, and State of residence. As a

result, I think the NHA team should work to ensure that the NHA will be able to answer policymakers' questions. To that end, the NHA should be as clear and as explicit as possible about the ways in which the MMA has reallocated spending among payers and its effects on overall national health spending. Therefore, I would recommend that the NHA team consider reclassifying some spending, or, at a minimum, issuing sidebar tables that clarify the nature of the transfers in the MMA.

First, I think that the NHA as envisioned by the NHA team's proposal will understate contributions by the States in two ways. The decision to count premiums and coinsurance paid by the States on behalf of dually eligible beneficiaries as Medicare expenditures does not give the States credit for these payments. In addition, the recent decision to count the State "maintenance of effort" payments as Medicare expenditures compounds the problem, further understating the contributions of the States. Moreover, the current presentation overstates actual Medicare spending. I believe that it is more appropriate to classify both of these types of State payments as State spending in the NHA. At a minimum, the NHA should include a sidebar table that adds these expenditures to the State spending totals so that policymakers who want to see the "bottom line" from the States' perspectives will be able to do so.

Second, I believe that subsidies paid by Medicare to private employers to persuade them to maintain health coverage for their retirees should be classified as Medicare, rather than private health insurance expenditures. After all, these subsidies reflect transfers from Medicare to private employers, and should properly be considered Medicare expenditures. Although some have argued that the subsidies are the equivalent of Medigap and employer retiree health benefits, I do not agree, because unlike those examples, in the case of the new retiree health subsidies, these are

payments from the Medicare program directly to employers. Therefore, I believe they are more appropriately classified as Medicare expenditures. At the least, I recommend that a sidebar table and accompanying explanation should be provided, so that policymakers who want to understand the extent to which Medicare is subsidizing the employers who provide retiree health insurance can do so.

From my experience in working with them at CMS, the NHA team and their colleagues at the Office of the Actuary work tirelessly and diligently to provide policymakers with the critical information they need to understand health care spending trends and make good decisions. I commend the NHA team for their thoughtful consideration of these complex issues. I hope that the NHA team will consider implementing our recommendations, which I believe will give policymakers a clearer understanding of the flows of Federal, State, and beneficiary funds under the MMA.