The Affordable Care Act
Health Care Spending in Montana
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Health Care Spending Under the Spotlight Again
In the past several years, national spending on health care has been at its lowest rate of growth in the 50-year history of the national health expenditures accounts. In 2009, spending grew by 4 percent compared to the average annual growth rate of 9.6 percent since 1960. The slowdown in spending growth is due to a deceleration of private health insurance and health care capital spending, as well as a decline in out-of-pocket spending by consumers during the recession.

While health care spending declined during the economic downturn, so did Gross Domestic Product (GDP). A measure of our nation’s economic health, nominal GDP experienced its largest drop (-2.5 percent in 2009) in 72 years. As a result, health care’s share of GDP increased a full percentage point in 2009 to 17.6 percent, the largest increase in the history of the national health expenditures accounts. In previous recessions, health care’s share of GDP also grew, but by much smaller shares. Health care spending as a share of GDP is expected to reach 19.8 percent by 2020 since spending is expected to grow at 6 percent annually for the foreseeable future, well above most expectations for growth in the nation’s economy.

Deficit Reduction and the “Doc Fix”
One immediate challenge facing Congress is the “doc fix,” a fee schedule with prices for more than 7,000 services used by Medicare beneficiaries. Current law requires the Centers for Medicare and Medicaid Services to update the 7,000 plus prices each year. In 1997, the Sustainable Growth Rate formula was introduced in an effort to keep spending for each Medicare enrollee from growing faster than the growth in per capita GDP.

At the time this article was written, physicians are still facing a 27.4 percent reduction in fee for service Medicare reimbursement in February. Since 2003, Congress has prevented cuts in physician payment schedules 12 times, instead granting increases or freezing the rates to prior year schedules.

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The Future of Physician Medicare Reimbursement
Should Congress pass a short-term fix to the Sustainable Growth Rate formula before the close of 2011, no offsetting revenues have to be found. Otherwise, Congress will have to find between $200 billion and $358 billion in new revenue over the next 10 years just for the “doc fix.” The Medicare Payment Advisory Commission proposed a $200 billion fix by freezing primary care physician office visit rates for 10 years, and reducing all other services, including those provided by non-primary care physicians by 5.9 percent per year until 2014. Thereafter, all services for all physicians are frozen until 2021. Although one of the lowest cost fixes, it faces stiff opposition by provider groups. Pharmaceutical companies would be required to give rebates to low-income Part D beneficiaries, skilled nursing facilities and clinical labs would...
face significant payment reductions, and excise taxes on Medigap plans – the supplemental plans Medicare beneficiaries purchase for physician services – would be imposed.

In a state with a disproportionate share of its citizens eligible for Medicare and a shortage of primary care physicians, failure to find a long-term fix for physician reimbursement could threaten access to medical care.

The Affordable Care Act and its Impact on Montana: Preliminary Evidence

Several provisions of the Affordable Care Act (ACA) may benefit 171,000 Medicare beneficiaries living in Montana. Medicare Part B, the Supplementary Medical Insurance Program, helps pay for physician, outpatient, home health, and preventive services. Of the 134,000 Montanans enrolled in Medicare Part B for 12 months or longer, 4 percent received an annual wellness exam at no cost, compared to 4.1 percent nationally. Several preventive services are also now provided at no cost to Medicare enrollees, including cardiovascular, bone mass, and diabetes screenings, mammograms, and many others. Nationally, 55.6 percent of Medicare Part B beneficiaries received at least one preventive service in the first 35 weeks of 2011, compared to only 42.1 percent of Montana’s Part B beneficiaries.

The Affordable Care Act makes Medicare prescription drug coverage (Part D) more affordable. Before the ACA, when the total retail cost of prescription drugs reached $2,930, the “donut hole,” Medicare beneficiaries were responsible for the full cost of prescription drugs until they reached a level of spending qualifying them for catastrophic coverage ($4,700). During 2010, those who reached the coverage gap received one-time rebate checks of $250. Beginning last year, those caught in the donut hole were eligible for a 7 percent discount for generics and a 50 percent discount for brand name drugs. For the first three-quarters of 2011, more than 6,000 Montanans qualified for $3.5 million in gap discounts, or $578 per beneficiary. Beginning in 2012, generic discounts increase to 14 percent and increase every year until 2020 when both generic and brand name drugs are discounted 75 percent.

Section 1102 of the ACA established the Early Retiree Reinsurance Program (ERRP) designed to help retirees ages 55-64 keep their employer-sponsored health insurance. ERRP was scheduled to end in 2014, but in May 2011, the program stopped accepting applications. Accumulated payments had already accounted for nearly 75 percent of the $5 billion appropriated by Congress. In Montana, ERRP payments totaled $3.8 million through October 2011, with all but 4 percent going to public employee health insurance programs. Montana state government received $1.4 million (38 percent), followed by public school systems (32 percent), the Montana University System (10 percent), city governments (9 percent), and county governments (7 percent). Yellowstone County alone accounts for 34 percent of the ERRP funds in Montana.

On the other side of the age spectrum, insurance plans offering dependent coverage now must offer the same coverage to enrollees’ adult children up to age 26. While the number of people benefiting from this provision is unknown for Montana, during the first quarter of 2011, nearly 1 million young adults throughout the U.S. between the ages of 19 and 25 gained health insurance coverage.

Perhaps one of the least successful aspects of the ACA is the small business tax credit. The credit has several qualifying conditions, including the proportion of the premium paid by the employer, the number of employees, the average wage, and a premium cap set for each state by the Department of Health and Human Services. Only 5 percent of qualifying small businesses throughout the nation applied for the credit by mid-May 2011. The disappointing response to the federal tax credit is blamed on several factors. First and foremost, businesses found it was simply not worth the time and effort to apply. To make matters worse, the tax form used for the credit, Form 8941, did not contain all the data and calculations necessary to verify each step on the form. In Montana, more than 26,000
postcards were sent to businesses that may qualify for the tax credit. Whether the 2011 tax year and beyond will increase business interest in the tax credit is unclear. Shopping for health insurance however may be easier for small businesses. The Department of Health and Human Services announced in November 2011 an expanded website for small businesses to shop for insurance, by zip code (see www.HealthCare.gov).

**Health Care Spending in Montana**

A benchmark for tracking health care trends, personal health care spending was $2.1 trillion throughout the nation in 2009, the most recent data available. Hospital care accounted for 36 percent of this spending, followed by physician and clinical services (24 percent), and prescription drugs (12 percent). This year, personal health care spending is projected to be $2.4 trillion, and by 2014, when the Affordable Care Act kicks into full gear, $2.7 trillion.

Personal health care spending in Montana is $7.2 billion this year, increasing to $8.2 billion by 2014. How this spending translates to health care jobs in Montana is a relevant policy question since Montana is disproportionately dependent on the health care industry. Only seven other states devote more of their respective GDP to health care than Montana. Health care was by far the major contributor to the 1.1 percent growth in Montana’s GDP from 2009 to 2010.

Using health care spending levels for the past 20 years and projecting them forward to 2014, health care earnings in Montana are estimated according to two scenarios, with and without the policies of the Affordable Care Act. How the health care sector responds to more health care spending is dependent upon whether health care providers can increase productivity or whether there is an expansion in the health care labor force.

Figure 1 shows the expected growth in health care labor earnings for Montana over the next three years, with and without implementation of the ACA. Earnings in Montana directly attributable to personal health care spending were $3.3 billion in 2010.

This year, personal health care spending in Montana is expected to increase by $163 million, supporting more than 5,900 jobs and generating nearly $256 million in earnings economy-wide. Not only are the average earnings ($43,000) well above average earnings for all private industries in Montana ($35,000), the average annual growth in earnings for health care over the past five years has considerably exceeded the growth in private earnings, 4.8 percent compared to only 1.7 percent.

**Conclusion**

Spending on health care will continue to have a bull’s-eye on its back for many years to come. Public health insurance programs alone consume one-fifth of all federal spending, making it a likely target in deficit reduction talks. Given its prominence in budget deliberations nationally, and state concerns about the future of Medicaid, health care will continually be under the budget-cutting scalpel. Certain for the short term, however, is that health care spending will continue to increase. An aging population, health insurance for the uninsured, and technological advances which extend life but do little to contain costs will be the main drivers behind health care spending for years to come and indirectly behind new job creation in health care. But the focus on the growth in health care spending will also limit job creation in the future. The health care industry will have incentives to outsource many of its administrative and technical jobs, adopt measures to increase productivity, and adapt to new payment models that will limit the number of procedures and instead reward providers on value-based delivery.