Health Spending and the Federal Budget

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We’re in a Lot of (Budgetary) Trouble
Federal Revenues and Primary Spending, by Category, Under CBO’s Long-Term Budget Scenario

Percent of GDP

Source: Congressional Budget Office, The Long-Term Budget Outlook, June 2010, revised August 2010.

Note: This alternative fiscal scenario follows closely to current law and follows CBO’s 10-year baseline budget projections through 2020 and extending the baseline concept through 2035, however this estimate incorporates a number of assumed exceptions to current law as of the August 2010 revision, including: (1) Medicare physician payment rates continue to grow at the Medicare economic index rather than following the SGR, (2) several policies to restrain spending after 2020 do not go into effect, i.e., IPAB recommendations do not go into effect, (3) health insurance premium subsidy cuts scheduled for 2020 do not take effect, and (4) the tax relief policies known as the “Bush tax cuts” are extended through 2020 after which individual income taxes are adjusted to keep total revenue constant as a share of GDP.
Historic Patterns: Federal Revenue and Outlays as a Percentage of GDP, 1950-2009

Source: Office of Management and Budget.
What Role Does Health Care (and Medicare and Medicaid, in Particular) Play in This Situation?
International Comparison of Spending on Health, 1980–2008

Average spending on health per capita ($US PPP)

Total expenditures on health as percent of GDP

SOURCE: OECD Health Data 2010 (June 2010).
Federal Spending on Medicare and Medicaid and Total Federal Spending as a Percentage of GDP, 1962-2082

Percentage of GDP

- **Medicare and Medicaid**
- **Total**

**NOTE:** Figures for 2007-2082 are projections; Total federal spending includes all federal non-interest spending.
Sources of Growth in Projected Federal Spending on Medicare, Medicaid and Social Security, 2010 to 2080

Percentage of GDP

Effect of Excess Cost Growth in Health Care Spending

Effect of Aging

In the Absence of Aging and Excess Cost Growth

NOTE: Excess cost growth refers to the extent to which growth in health spending per Medicare or Medicaid beneficiary exceeds the growth rate of per capita GDP.

SOURCE: Presentation by Robert A. Sunshine, CBO Deputy Director, in a presentation on Mandatory Spending to the National Commission on Fiscal Responsibility and Reform, May 12, 2010.
### Proportion of Projected Growth in Federal Spending on Major Health Care Programs and Social Security Attributable to Aging and Excess Cost Growth

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Aging</th>
<th>Excess Cost Growth</th>
</tr>
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<tbody>
<tr>
<td>Major Health Programs and Social Security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010-2035</td>
<td>63</td>
<td>37</td>
</tr>
<tr>
<td>2010-2080</td>
<td>44</td>
<td>56</td>
</tr>
<tr>
<td>Major Health Programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010-2035</td>
<td>45</td>
<td>55</td>
</tr>
<tr>
<td>2010-2080</td>
<td>29</td>
<td>71</td>
</tr>
</tbody>
</table>

**NOTE:** Excess cost growth refers to the extent to which growth in health spending per Medicare or Medicaid beneficiary or per other person exceeds the growth rate of per capita GDP.

**SOURCE:** Congressional Budget Office, *The Long-Term Budget Outlook*, June 2010 (Revised August 2010).
Rising Cost of Care is a Shared Concern: Public and Private Growth In Private Spending per Person Projected to Exceed Medicare, 2009-2019

Average Annual Growth in Medicare and Private Health Insurance Benefits Per Enrollee: Selected Periods

Except for 1993–1997, Medicare has grown slightly more slowly than private health insurance.

Source: CMS, Office of the Actuary, National Health Statistics Group; from presentation by Marilyn Moon to AcademyHealth Health Policy Orientation, October 2009.
Proposals to Slow Down (Federal) Health Spending
## Major Health Policies Proposed in Deficit Reduction Proposals (Round I)

<table>
<thead>
<tr>
<th>National Commission on Fiscal Responsibility and Reform (Simpson-Bowles)</th>
<th>Bipartisan Policy Center Debt Reduction Task Force (Domenici-Rivlin)</th>
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<tbody>
<tr>
<td>Reform Sustainable Growth Rate mechanism for determining Medicare physician fee updates (costs $240B)</td>
<td>Phase out tax exclusion for employer-sponsored health insurance beginning in 2018 (saves $113B)</td>
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<td>Reform or repeal CLASS Act (costs $76B)</td>
<td>Raise Medicare Part B premiums (saves 123B)*</td>
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<tr>
<td>Extend Medicaid rebates to Medicare/Medicaid dual eligibles in Medicare Part D (saves $49B)</td>
<td>Increase rebates for Part D drugs (saves $100B)*</td>
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<td>Reduce Medicare payments to hospitals for graduate medical education (saves $60B)</td>
<td>Redesign Medicare cost-sharing (saves $14B)*</td>
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<tr>
<td>Reform Medicare cost-sharing rules, cap beneficiary out-of-pocket spending, restrict first-dollar coverage in Medicare supplemental insurance (saves $110B)</td>
<td>Bundle Medicare payment for acute and post-acute care (saves $5B)*</td>
</tr>
<tr>
<td>Restrict first-dollar coverage in TRICARE for Life (saves $38B)</td>
<td>Transition Medicare to premium support, beginning in 2018 (saves $172B)</td>
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<tr>
<td>Enact malpractice reform (saves $17B)</td>
<td>Eliminate barriers to enrollment in managed care options for dual eligibles (saves $5B)*</td>
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<tr>
<td>Enact premium support pilot for federal employees (saves $18B)</td>
<td>Incentivize government to control Medicaid cost growth (saves $20B)</td>
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<tr>
<td>Reduce Medicare fraud (saves $9B)</td>
<td>Cap non-economic and punitive damages for malpractice (saves $48B)</td>
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<tr>
<td>Cut Medicare payments to providers for bad debts (saves $23B)</td>
<td>Introduce excise tax on sweetened beverages (saves $156B)</td>
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<td>Accelerate home health payment changes in the ACA (saves $9B)</td>
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<td>Place dual eligibles in Medicaid managed care ($12B)</td>
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<td>Reduce funding for Medicaid administrative costs ($2B)</td>
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<td>Broaden scope of Independent Payment Advisory Board to all federal health spending</td>
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# Major Health Policies Proposed in Deficit Reduction Proposals (Round II)

<table>
<thead>
<tr>
<th>House Republican Budget Resolution</th>
<th>President’s Framework</th>
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<tr>
<td>Assumes “doc fixes” are continued and fully offset</td>
<td>Assumes continuation of “doc Fixes”</td>
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<tr>
<td>Repeals the tax and coverage provisions from health care reform, but keeps most Medicare savings (but not the Independent Payment Advisory Board)</td>
<td>Proposes health care savings from standardizing the Medicaid matching rate, prescription drug reforms, patient safety initiatives, and anti-fraud measures</td>
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<tr>
<td>Block-grants Medicaid in 2013 and holds growth to rate of inflation plus population growth</td>
<td>Strengthens Independent Payment Advisory Board by broadening its mandate and limiting Medicare per beneficiary growth to GDP+0.5% instead of GDP+1%</td>
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<td>Enacts tort reform</td>
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<td>Transforms Medicare to premium support program in 2022 and limits per beneficiary growth of premium support inflation</td>
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</table>

**SOURCE:** Committee for a Responsible Federal Budget, Summary Table of Fiscal Plans, April 2011, available at [http://crfb.org/sites/default/files/CRFB_Fiscal_Plans_Summary_Table.pdf](http://crfb.org/sites/default/files/CRFB_Fiscal_Plans_Summary_Table.pdf)
But Focusing Only on Federal Budget Outlays Won’t Solve the Problem

- Rising health spending is putting increasing pressure not only on the federal budget but also on state and local budgets, businesses, and households
  - Median out-of-pocket spending by Medicare beneficiaries was 16.2% of household income in 2006, and has been rising; much higher for low-income, older, and sicker beneficiaries
  - Medicaid pressure on state budgets
  - “GM spends more on health care than on steel” and “Starbucks spends more on health care than it does on coffee beans”
  - Although out-of-pocket spending on health care is a smaller proportion of the total, it has been growing much faster than workers’ wages

- The driving factor in both public and private health spending growth is excess cost growth

- We need policies that address underlying cost growth, rather than just shifting the burden of dealing with it from the federal government to others
So What Can Be Done?

Source: 2010 Commonwealth Fund International Health Policy Survey in Eleven Countries.
Slowing Health Spending Growth in the Context of the Federal Deficit: Guiding Principles

• Focus on total costs, not just federal
  – Same factors contribute to rising private and public costs

• Enhance and/or protect access and quality

• Pay attention to distributional effects
  – Medicare and Medicaid insure vulnerable: income and health
  – Historic rationale for programs remains

• Emphasize need to improve performance
  – Should expect more for current investment
  – Value based benefits and purchasing policies

• Need all-payer coherence/leverage to align incentives
  – Payment methods AND levels matter
  – Move away from fee for service and toward accountability
  – Medicare acting alone has unintended consequences
Finding a Way Forward in Context of Federal Deficit

- Develop integrated set of policies that blend market oriented approaches and social insurance values
  - Draw from ideas across policy spectrum where of potential value
  - Emphasis on reducing federal, state/local and private health care costs compared to projected trends
  - Willingness to be bold

- Mixed public and private—align payment policies
  - All payer: national and regional
    - Budget targets and authority
    - IPAB jurisdiction expanded to private and Medicaid
      - Regional target growth rates
      - Design to reduce price spread and align methods

- More integrated insurance markets with transparency
- Align incentives in health care markets
- Medicare and Medicaid policy reforms (next chart)
Medicare and Medicaid Policy Reforms

**Medicare**
- Integrated benefits: value based design and reference pricing
  - Eliminate need for Medigap and Part D; Modest cost-sharing
  - Waivers from copayments if designate medical home, accountable care organization (ACO)
- Medicaid “wrap-around” for low income beneficiaries
- Payment policy: move rapidly to more bundled payment
  - Primary care medical home, ACOs
  - Expand acute care bundle to 30-days post-discharge
  - Revised physician fee schedule, rewards for high performance

**Medicaid**
- Acute care payment policy aligned with Medicare
- Align with exchanges
  - Medicaid covered through exchanges: platinum plus?
  - Wrap around policy for supplemental—including long term care
- Personal care/home health linked to organized care systems